Original Application

Crestwyn Behavioral Health Memphis (Shelby Co.)

CN1803-018

DSG Development Support Group

March 15, 2018

Melanie Hill, Executive Director Tennessee Health Services and Development Agency Andrew Jackson Building, 9th Floor 502 Deaderick Street Nashville, TN 37243

RE:

CON Application Submittal Crestwyn Behavioral Health Gemantown, Shelby

ihm Wellow

Dear Mrs. Hill:

This letter transmits an original and two copies of the subject application. The affidavit and filing fee are enclosed.

I am the contact person for this project. Brant Phillips is legal counsel. Please advise me of any additional information you may need. We look forward to working with the Agency on this project.

Respectfully,

Jøhn Wellborn Consultant

CERTIFICATE OF NEED APPLICATION CRESTWYN BEHAVIORAL HEALTH GERMANTOWN, SHELBY COUNTY

FOR THE ADDITION OF 14 PSYCHIATRIC BEDS

Filed March 2018

CERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

1. Name of Facility, Agency, or Institution

Crestwyn Behavioral Health		
Name		
9485 Crestwyn Hills Cove		Shelby
Street or Route		County
Memphis	TN	38125
City	State	Zip Code
www.crestwynbh.com		
Website Address		

2. Contact Person Available for Responses to Questions

John Wellborn	Consultant			
Name	Title			
Development Support Group	jwdsg@comcast.net			
Company Name	E-Mail Address			
4219 Hillsboro Road, Suite 210	Nashville	TN	37215	
Street or Route	City	State	Zip Code	
CON Consultant	615-665-2022		615-665-2042	
Association With Owner	Phone Nun	Fax Number		

NOTE: Section A is intended to give the applicant an opportunity to describe the project. Section B addresses how the project relates to the criteria for a Certificate of Need by addressing: Need, Economic Feasibility, Contribution to the Orderly Development of Health Care, and Quality Measures. Please answer all questions on 8.5" X 11" white paper, clearly typed and spaced, single-sided, in order and sequentially numbered. In answering, please type the question and the response. All questions must be answered. If an item does not apply, please indicate "N/A" (not applicable). Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed and signed notarized affidavit.

3. SECTION A: EXECUTIVE SUMMARY

A. Overview

Please provide an overview <u>not to exceed three pages in total</u>, explaining each numbered point.

(1) Description (Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant.)

Crestwyn Behavioral Health ("CBH") is a 66-bed acute care mental health in the Germantown area of southeast Shelby County. It offers adult and geriatric adult psychiatric care; adolescent psychiatric care; and dual diagnosis (psychiatric and substance abuse) care.

The hospital is a joint venture among two Memphis acute care providers--Baptist Hospital and St. Francis Hospital--and Crestwyn Health Group, LLC. The latter is a subsidiary of Acadia Healthcare, a national behavioral healthcare company headquartered in Tennessee. Acadia partners with not-for-profit hospital systems across the country and across Tennessee.

Responding to this collaborative effort, the HSDA granted Crestwyn CN1310-040 for 60 beds in January 2014; and the hospital opened in 2016. Its CON application had projected attaining 45% occupancy in its first full calendar year of operation. However, the service area's needs filled Crestwyn to 73.5% occupancy in its first full calendar year of operation (2017). Crestwyn projects exceeding 80% average occupancy for this current calendar year.

In July, the Tennessee Department of Mental Health and Substance Abuse Services (DMHSAS) increased Crestwyn's license from 60 to 66 beds, under the exemption allowance in the CON statute. The 6 additional beds have been put into service in existing patient rooms, and the 66-bed complement has been more than 83% occupied in the early weeks of this year.

Crestwyn's 40 patient rooms were all built for semiprivate occupancy. Under its 66-bed license, 26 of those rooms are now equipped as semi-privates (52 beds) and 14 are equipped as private rooms (14 beds).

This project will place 14 more beds in Crestwyn's remaining semi-private size rooms without any new construction. The addition will result in 80 licensed beds in 40 semiprivate rooms--the maximum complement Crestwyn can license without constructing an additional wing of beds. As needed, semi-private rooms can be restricted to private occupancy to provide for appropriate separation or isolation.

	Table A-3A(1a): Crestwyn Beh	avioral Health	
	Proposed	Changes in Licen	sed Beds	
	CY 2016 Beds	CY2018 Beds	Proposed Beds	Change in Beds
Adult	30	33	36	+3
Adolescent	15	16	32	+16
Dual Diagnosis	15	17	12	-5
Total	60	66*	80	+14

^{* 6} bed license increase granted by TDMHSAS under exemption clause in CON statute.

Table A-3A(1b): Crestwyn Behavioral Health Changes in Bed Capacity, Licensed Beds, and Type of Room							
Phase	Rooms	Room Size	Bed Capacity	Beds Licensed	Change	Semi- private Use	Private Use
At Opening 2016	40	SP	80	60		20 rooms 40 beds	20 rooms 20 beds
Currently 2018	40	SP	80	66	+6	26 rooms 52 beds	14 rooms 14 beds
Proposed 2019	40	SP	80	80	+14*	40 rooms 80 beds	As Needed

^{*} Currently there are 14 semiprivate size rooms being used as private rooms (one patient only) due to CON restrictions.

(2) Ownership Structure

The applicant and license holder is "Crestwyn Health Group, LLC DBA Crestwyn Behavioral Health". It is jointly owned by three entities listed in the table below. Acadia Crestwyn Holdings, LLC, the majority member of the CON applicant and licensee, is a wholly owned subsidiary of Acadia Healthcare. Acadia Amisub (SFH), Inc. is the local subsidiary of Saint Francis Hospital's national parent, Tenet. Baptist Memorial Health Services, Inc, is an entity of the Baptist Hospital System of Shelby County. The facility is member-managed by the LLC's majority member Acadia Healthcare; no formal management contract is being utilized.

Table A-3A(2): Ownership of the Applicant Crestwyn Health Group, LLC DBA Crestwyn Behavioral Health			
Name of Owning Entity Percentage of Membership Interests			
Acadia Crestwyn Holdings, LLC	60%		
Amisub (SFH), Inc.	20%		
Baptist Memorial Health Services, Inc.	20%		

3) Service area

• Crestwyn's admissions last year came from 103 counties in Tennessee and other States. They came from 60 Tennessee counties. However, approximately 60% are from Shelby County, and only one other county contributed 3%. Fifty-three counties contributed 1% or less.

Therefore Shelby County is being declared as the applicant's primary service area ("PSA") with 25 other Tennessee, Mississippi, and Arkansas counties being included as secondary service area ("SSA") counties. Knox, Davidson, and Rutherford Counties contribute 9-11 annual admissions as well, more than some of the listed counties, but each constitutes less than 1% of admissions and is too far away to be identified in a a largely contiguous secondary service area.

Ta	ble A-3A(3): Service Area (W	
	Primary Service 2	Area
	Shelby County	y
Secondary Se	ervice Area Counties in Tennes	ssee, Arkansas, Mississippi (25)
Benton	Fayette	Lauderdale
Benton MS	Gibson	Lawrence AR
Carroll	Hardeman	Madison
Chester	Hardin	Marshall MS
Crittenden AR	Haywood	McNairy
Crockett	Henderson	Obion
Decatur	Henry	Tipton
Desoto MS	Fayette	
Dyer	Lake	

• Based on last year's patient origin at Crestwyn there will also be referrals from counties and States beyond these areas, comprising approximately 13% of admissions.

(4) Existing similar service providers

- In the primary service area (PSA) there are 14 licensed providers offering acute inpatient behavioral care. They consist of dedicated behavioral health hospitals and behavioral health units of general hospitals. Of those providers, 7 are in Shelby County; 6 are in other West Tennessee counties; and 1 is in nearby Mississippi.
- The providers include State mental health hospitals in West Tennessee, privately owned hospitals, and distinct-part behavioral units of general hospitals. A full list of all the area's providers, bed complements, and addresses is provided in Section B.Need.3 of the application.

(5) Project cost

• The project cost consists of the CON process cost and furniture for existing patient rooms. This minimal project cost estimated at \$91,000.

(6) Funding

• Crestwyn Behavioral Health, the applicant, will fund the small capital costs of the project.

(7) Financial feasibility, including when the proposal will realize a positive financial margin; and

- This is an existing hospital that operates with a positive margin. The project cost is minimal. The project when implemented will not reduce the hospital's already positive operating margin.
- The hospital has available funds to implement the project.

(8) Staffing

• The project will require only 6.5 additional FTE's for direct and non-direct patient care. They will be approximately 2 nurses, two mental health techs, and a therapist.

B. Rationale for Approval

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of adequate and effective health care in the service area. This section should provide rationale for each criterion using the data and information points provided in Section B of this application. Please summarize, in one page or less, each of the criteria.

(1) Need

Crestwyn Behavioral Health is a highly regarded 66-bed mental health hospital in Shelby County. It is an innovative joint venture among three hospital systems: Baptist Hospital, St. Francis Hospital, and Acadia Healthcare (which is a behavioral healthcare company headquartered in Tennessee, with facilities worldwide.) The project for which it seeks HSDA approval is the licensure of 14 more psychiatric beds in existing hospital rooms, at a minimal capital cost involving only furnishings, not construction.

The project responds to an area need for more inpatient treatment capacity at Crestwyn, identified by numerous local mental health agencies working in this service area--such as the National Alliance on Mental Illness (NAMI), Youth Villages and Alliance Healthcare Services (TennCare's two designated crisis intervention teams for West Tennessee), Serenity Recovery Center, Professional Care Services of West Tennessee, and other significant organizations and elected officials.

Crestwyn has a large primary and secondary service area of 31 counties with 1,152 psychiatric beds, including beds at two State mental health hospitals. This small project would increase the area's licensed beds by only 14 beds. But those beds will relieve a daily shortage of capacity at a facility whose adult and child/adolescent psychiatric beds now operate at more than 90% occupancy. The bed increase and an internal reassignment of other beds will allow Crestwyn to double its complement of child and adolescent beds and to continue to work closely with community agencies who depend on its bed availability.

This will allow the dual diagnosis beds to operate at high efficiency (almost 87% in Year Four, CY2022). It will provide room for program growth in adult and adolescent programs, which are currently full and are turning away admissions requests for lack of bed availability. With demand trends continuing, Crestwyn anticipates reaching overall 82% occupancy in Year Two of this project (2020) and 90% occupancy in Year Five (2023).

Crestwyn is a good partner to its community. It operates with a 48% TennCare, self-pay, and charity payor mix. It was opened in 2016 without the licensure of any additional beds to the service area, thanks to beds contributed to it by three hospital systems. This time, Crestwyn is requesting a very small 1.2% increase in service area bed complements, in order to completely fill its designed capacity. The project is based on this provider's needs; but the provider plays an important role in Shelby County and the rest of West Tennessee. Its modest increase in capacity will help the communities it serves, and the agencies who are supporting the project.

In addition, the service area's patient days for behavioral care increased more than 15,000 days in the past two JAR reporting years. The 14 beds requested by Crestview, at 100% occupancy, could not provide more than 5,110 patient days of care. It appears that normal growth in area demand for this type of care will more than offset the impact that the additional 14 beds could have on other providers.

(2) Economic Feasibility

Crestwyn Behavioral Health currently operates with a positive cash flow and positive operating margin. The proposed bed additions will be accomplished at a very low capital cost, without new debt service, and the beds will allow for increased admissions and increased revenues. The Projected Data Charts in the application demonstrate the economic feasibility of the facility both currently, and with the project operational.

The very minor capital funding required for Phase One of this project will be provided by the hospital, whose financial statements document the availability of sufficient funds.

(3) Appropriate Quality Standards

The hospital is currently licensed by the Tennessee Department of Mental Health and Substance Abuse Services, and is fully accredited by the Joint Commission. It meets all relevant quality standards of those organizations--and of Acadia Healthcare, which has strong quality improvement programs in its hospital facilities.

(4) Orderly Development of adequate and effective health care

Crestwyn's approval in CY2014 reflected a CON Board consensus that there was a need to better distribute inpatient acute psychiatric beds into southeast Shelby County. The application projected that this would be met by a region-wide demand for, and high utilization of, beds at that location.

The projection was validated by the referrals that Crestwyn experienced in its first year of operation, from virtually all of West Tennessee and from adjoining States. This reflects the effectiveness of its care in the eyes of the region and referring caregivers. Crestwyn's adult and child and adolescent beds are full. This proposed 14-bed filling-out of existing patient bed spaces, with a reassignment of some of the dual diagnosis beds to child and adolescent care, will add to the facility's effectiveness in meeting regional needs.

This phased expansion can be accomplished in an orderly way, and at a very economical cost, because the hospital was prudently designed to allow for future conversions of single-occupancy patient rooms to semiprivate rooms as needed, without additional construction. This increase in licensed bed capacity will not necessitate construction of new bed capacity.

Crestwyn Behavioral Health opened less than two years ago. Its innovative ownership model was a first for the State of Tennessee. Two large local non-profit and for-profit hospital systems joined a national behavioral care system, to demonstrate the effectiveness of joint efforts and deep expertise in managing inpatient behavioral health needs of adolescents and adults. This joint ownership approach has inspired superior consumer confidence in the region, filling Crestwyn's beds to overflow in a matter of months. This application requests approval of an orderly, phased expansion of a facility that many referral sources in the region regard as a destination of choice.

C. Consent Calendar Justification

If consent calendar is requested, please provide the rationale for an expedited review. A request for Consent Calendar must be in the form of a written communication to the Agency's Executive Director at the time the application is filed.

Not applicable.

SECTION A (CONTINUED): PROJECT DETAILS

4.A. Owner of the Facility, Agency, or Institution

Crestwyn Health Group, LLC DBA Crestwyn Behavioral Health		901-248-1495	
Name		Phone Number	
c/o Acadia Healthcare, 6100 Tower Circle, S	uite 1000	Davidson	
Street or Route		County	
Franklin	TN	37067	
City	State	Zip Code	

B. Type of Ownership or Control (Check One)

	F. Government (State of TN or	
A. Sole Proprietorship	Political Subdivision)	
B. Partnership	G. Joint Venture	
C. Limited Partnership	H. Limited Liability Company	X
D. Corporation (For-Profit)	I. Other (Specify):	
E. Corporation (Not-for-Profit)		

Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the TN Secretary of State's website hpps://tnbear.tn.gov/Ecommerce/FilingSearch.aspx.

See Attachment Section A-4A.

<u>Describe</u> the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest.

An organization chart is included in Attachment Section A-4A. The applicant is a joint ventured, limited liability company. It is 40% owned by Acadia Healthcare, Inc. (a publicly traded national behavioral healthcare company), and by two Shelby County hospital providers, Baptist Memorial Hospital, Inc. (20%) and Amisub (SFH), Inc. (20%). The latter is a legal entity representing St. Francis Hospital, wholly owned by Tenet Healthcare, a multinational healthcare system headquartered in Dallas, Texas.

5A. Name of Management/Operating Entity (If Applicable) NA

The LLC is member-managed.

Name		
Street or Route		County
City	State	Zip Code

For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.

Not applicable.

6A. Legal Interest in the Site of the Institution (Check One)

A. Ownership	X	D. Option to Lease	
B. Option to Purchase		E. Other (Specify):	
C. Lease of Years			

Check appropriate line above: For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements <u>must include</u> anticipated purchase price. Lease/Option to Lease Agreements <u>must include</u> the actual/anticipated term of the agreement <u>and</u> actual/anticipated lease expense. The legal interests described herein <u>must be valid</u> on the date of the Agency's consideration of the certificate of need application.

See Attachment Section A-6A for a copy of the deed.

- 6B. Attach a copy of the site's plot plan, floor plan, and if applicable, public transportation route to and from the site, on an 8.5" X 11 sheet of white paper, single-sided. Do not submit blueprints. Simple line drawings should be submitted and need not be drawn to scale.
- (1) Plot Plan must include:
 - a. Size of site (in acres);
 - b. Location of structure on the site;
 - c. Location of the proposed construction/renovation; and
 - d. Names of streets, roads, or highways that cross or border the site.

See Attachment A-6B-1 for the facility's plot plan.

(2) Attach a floor plan drawing for the facility, which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. On an 8.5" X 11" sheet of paper or as many as necessary to illustrate the floor plan.

See Attachment A-6B-2 for floor plans depicting existing and proposed patient beds.

(3) Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

The table on the following page provides drive times and distances from the Crestwyn site to the principal communities in the primary and secondaryservice area counties.

The service area map in this application shows that the primary service area counties have access to Crestwyn via good highways. Via Winchester Road, Crestwyn's site is approximately 15 minutes' drive from I-240, the interstate loop around Memphis, crossed by numerous Interstate and U.S. highways radiating out in all directions: U.S. 51, U.S. 79, I-40, and U.S. 64 northwest and west across West Tennessee; U.S. 72 and U.S. 78 southeast across Mississippi; U.S. 61 and I-55 south across Mississippi; U.S. 64, I-40 and U.S. 79 West and southwest across Arkansas; and U.S 61, U.S. 63, and I-55 north into Arkansas.

Crestwyn also has access to I-40 Exit 16, via Highway 177 North and Poplar Avenue / Winchester Road. That route allows patients driving in on I-40 from rural West Tennessee to leave I-40 and head due south into Germantown, before reaching heavy traffic on the I-240 loop around Memphis.

The Memphis Area Transit Authority's closest municipal bus service stop is Winchester and Hacks Cross, approximately 2.8 miles from the campus.

Table A-6B(3): Mileage and Drive Times Between the Project and Major Communities in the Primary Service Area					
Counties	Community	Distance in Miles	Drive Time		
West Tennessee					
Benton	Camden	143	132 min.		
Carroll	Huntingdon	117	112 min.		
Chester	Henderson	83	95 min.		
Crockett	Alamo	79	84 min.		
Decatur	Decaturville	114	130 min.		
Dyer	Dyersburg	91	102 min.		
Fayette	Somerville	40	43 min.		
Gibson	Humboldt	93	89 min.		
Hardeman	Bolivar	58	65 min.		
Hardin	Savannah	102	113 min.		
Haywood	Brownsville	62	60 min.		
Henderson	Lexington	109	102 min.		
Henry	Paris	143	141 min.		
Lake	Tiptonville	117	134 min.		
Lauderdale	Ripley	69	80 min.		
Madison	Jackson	87	83 min.		
McNairy	Selmer	80	87 min.		
Obion	Union City	132	135 min.		
Shelby	Memphis (Center)	25	27 min.		
Tipton	Covington	51	65 min.		
Weakley	Martin	133	136 min.		
Mississippi					
Benton MS	Ashland	43	47 min.		
DeSoto MS	Horn Lake	29	33 min.		
Marshall MS	Holly Springs	31	39 min.		
Arkansas					
Crittenden AR	Marion	36	39 min.		
Lawrence AR	Walnut Ridge	116	110 min.		

Source: Google Maps, July 2017

7. Type of Institution (Check as appropriate-more than 1 may apply)

A. Hospital (Specify):		H. Nursing Home	
B. Ambulatory Surgical Treatment		I. Outpatient Diagnostic Center	
Center (ASTC) Multi-Specialty			
C. ASTC, Single Specialty		J. Rehabilitation Facility	
D. Home Health Agency		K. Residential Hospice	
E. Hospice		L. Non-Residential Substitution-	
		Based Treatment Center for	
		Opiate Addiction	
F. Mental Health Hospital	X	M. Other (Specify):	
G. Intellectual Disability			
Institutional Habilitation Facility			
ICFF/IID			

8. Purpose of Review (Check as appropriate—more than 1 may apply)

A. New Institution	F. Change in Bed Complement Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation	X
B. Modifying an ASTC with limitation still required per CON C. Addition of MRI Unit D. Pediatric MRI	G. Satellite Emergency Department H. Change of Location I. Other (Specify):	
E. Initiation of Health Care Service as defined in TCA Sec 68-11-1607(4) (Specify)		

9. Medicaid/TennCare, Medicare Participation

MCO Contracts (Check all that apply:
x Amerigroup x United Healthcare Community Plan x BlueCare
TennCare Select
Medicare Provider Number: 44-4025
Medicaid Provider Number: Q023745
Certification Type: Mental Health Hospital
If a new facility, will certification be sought for Medicare or for Medicaid/TennCare?
Medicare Yes No N/A x
Medicaid/TennCare Yes No N/A x

10. Bed Complement Data

A. Please indicate current and proposed distribution and certification of facility beds.)

	Beds Currently Licensed	Beds Staffed	Beds Proposed	*Beds Approved	**Beds Exempt	TOTAL Beds at Completion
1. Medical	Licenseu	Statted	Froposeu	Approveu	Exempt	Completion
2. Surgical						
3. ICU/CCU						
4. Obstetrical						
5. NICU						
6. Pediatric						
7. Adult & Geriatric						
Psychiatric	33	33	+3			36
8. Geriatric Psychiatric	33					
9. Child/Adolescent	16					
Psychiatric Psychiatric	(adolesc)	16	+16			32
10. Rehabilitation	(ddorese)	10				
11. Adult Chemical						
Dependency / Dual						
Diagnosis	17	17	-5			12
12. Child/Adolescent						
Chemical Dependency						
13. Long-Term Care						
Hospital						
14. Swing Beds						
15. Nursing Home SNF		· ·				
(Medicare Only)						
16. Nursing Home NF						
(Medicaid Only)						
17. Nursing Home						
SNF/NF (dually						
certified MCare/Maid)						
18. Nursing Home-						
Licensed (Noncertified)						
19. ICF/IID						
20. Residential Hospice						
TOTAL	66	66	+14	0	0	80

^{*} Beds approved but not yet in service

^{**} Beds exempted under 10% / 3 yrs provision

B. Describe the reasons for change in bed allocations and describe the impact the bed changes will have on the applicant facility's existing services.

Adding 14 additional beds will allow Crestview Behavioral Health to expand its level of service to the community, in its current inpatient psychiatric programs for geriatric and non-geriatric adults and for child and adolescent programs. It will provide a platform for moving from purely adolescent care into a children's program after two years.

C. Please identify all the applicant's outstanding Certificate of Need projects that have a licensed bed change component. If applicable, complete the chart below.

Acadia Healthcare Company, Inc., the majority owner of the applicant LLC, has two outstanding Tennessee Certificates of Need, as follows.

CON Number	CON Expiration Date	Total Licensed Beds Approved
CN1606-024	December 1, 2019	88 beds to be added
CN1603-012	October 1, 2019	88 bed new facility

11. Home Health Care Organizations – Home Health Agency, Hospice Agency (excluding Residential Hospice), identify the following by checking all that apply:

Not applicable.

12. COST PSF TABLE

Not applicable; the project has no construction cost.

13. MRI, PET, and/or LINEAR ACCELERATOR

None of Section A.13 (A-F) below is applicable to this project.

<u>Describe</u> the acquisition of any Magnetic Resonance Imaging (MRI) scanner that is adding an MRI scanner in counties with population less than 250,000, or is initiating pediatric MRI in counties with population greater than 250,000, <u>and/or describe</u> the acquisition of any Positron Emission Tomography (PET) unit or Linear Accelerator unit if initiating the service by responding to the following:

A. Complete the Chart below for acquired equipment.

LIN	NEAR ACCELERATOR
Mev:	Total Cost*: \$
Types: (indicate one)	By Purchase?
SRS	By Lease?
IMRT	
IGRT	Expected Useful Life (yrs):
Other:	New?
	Refurbished?
	If not new, how old (Yrs)?

	MRI
Tesla:	Total Cost*: \$
Magnet: (indicate one)	By Purchase?
Breast	By Lease?
Extremity?	
Open?	Expected Useful Life (yrs):
Short Bore?	New?
Other	Refurbished?
	If not new, how old (Yrs)?

	PET
PET Only?	Total Cost*: \$
	By Purchase?
PET/CT?	By Lease?
PET/MRI?	Expected Useful Life (yrs):
	New?
	Refurbished?
	If not new, how old (Yrs)?

^{*}As defined by Agency Rule 0720-9-.01(13)

vendor. In the case of equi	t purchase, include a quote and/or proposal from an equipment pment lease, provide a draft lease or contract that at least se and the anticipated lease payments along with the fair market
NA	
	of the equipment to its fair market value. Note: Per Agency rule, ntified in the project cost chart.
NA	

D. Schedule of Operations:

NA

Location	Days of Operation (Sun-Sat)	Hours of Operation
Fixed Site (Applicant)		
Mobile Locations		
Applicant		
Name of other location		

E. Identify the clinical applications to be provided, that apply to the project.

NA

F. If the equipment has been approved by the FDA within the past five years, provide documentation of the same.

NA

SECTION B: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with T.C.A. § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of health care." Further standards for guidance are provided in the State Health Plan developed pursuant to T.C.A. § 68-11-1625.

The following questions are listed according to the four criteria: (1) Need, (2) Economic Feasibility, (3) Applicable Quality Standards, and (4) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. Please type each question and its response on an 8 1/2" x 11" white paper, single-sided. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer, unless specified otherwise. If a question does not apply to your project, indicate "Not Applicable (NA)."

QUESTIONS

NEED

1. Provide a response to each criterion and standard in Certificate of Need categories in the State Health Plan that are applicable to the proposed project. Criteria and standards can be obtained from the THSDA or found on the agency's website at http://tjn.gov/hsda/article/hsda-criteria-and-standards.

STATE HEALTH PLAN CERTIFICATE OF NEED STANDARDS AND CRITERIA FOR PSYCHIATRIC INPATIENT SERVICES

Standards and Criteria

1. Determination of Need: The population-based estimate of the total need for psychiatric inpatient services is a guideline of 30 beds per 100,000 general population, using population estimates prepared by the TDH and applying the applicable data in the Joint Annual Report (JAR). These estimates represent gross bed need and shall be adjusted by subtracting the existing applicable staffed beds including certified beds in outstanding CONs operating in the area as counted by the TDH in the JAR. For adult programs, the age group of 18-64 years shall be used in calculating the estimated total number of beds needed; additionally, if an applicant proposes a geriatric psychiatric unit, the age range 65+ shall be used. For child inpatients, the age group is 12 and under, and if the

program is for adolescents, the age group of 13-17 shall be used. The HSDA may take into consideration data provided by the applicant justifying the need for additional beds that would exceed the guideline of 30 beds per 100,000 general population. Special consideration may be given to applicants seeking to serve child, adolescent, and geriatric inpatients. Applicants may demonstrate limited access to services for these specific age groups that supports exceeding the guideline of 30 beds per 100,000 general population. An applicant seeking to exceed this guideline shall utilize TDH and TDMHSAS data to justify this projected need and support the request by addressing the factors listed under the criteria "Additional Factors".

Rationale: Many communities in Tennessee have unique needs for inpatient psychiatric beds. The above formula functions as a "base criteria" that allows applicants to provide evidence supporting a need for a higher number of beds in the proposed service area. The HSDA may take into account all evidence provided and approve applications that request beds that exceed the 30 beds per 100,000 guideline when needed. An analysis of admissions and discharges by age category performed by the HSDA suggests there may be limited access for inpatients under the age of 18 and inpatients aged 65 and over. However, the applicable JAR form does not provide occupancy rates by age category. Health Planning believes developing determination of need formulas specific to each age category is not possible at this time due to these limitations in available data. The current need formula is to be utilized as a guideline allowing applicants the opportunity to apply to serve the unique needs of the intended service area.

Response:

The State Health Plan uses a planning standard of 30 beds per 100,000 population, making no distinctions between use rates by age. The 30-bed standard is to be applied to children, adolescents, and all adults. While the HSDA default planning horizon is four years from the present year, a later section of the State Plan criteria asks for a two-year projection. The applicant is providing both.

On the next page, tables identify net bed needs and surpluses using the most recent JAR information and licensing records. Approval of this project will increase total licensed beds in the project service area by only 1.2%. It will increase Shelby County beds by only 1.8%.

On the second following page, the applicant has applied the State methodology to project bed need for the three age cohorts, and for both the primary and secondary service areas.

Crestwyn and some other behavioral health facilities have very large multi-State service areas. Crestwyn's extends far beyond West Tennessee and nearby Mississippi and Arkansas counties. It is problematic to make CON findings relying exclusively on bed surplus calculations for just its immediate service area, when Crestwyn receives admissions from 103 U.S. counties.

Table Need-State Health Plan-Standard 1A: Service Area	
Using State Health Plan Standard of 30 Beds Per	100,000 Population
PROJECTION FOR CY2020	
Combined Primary and Secondary Service Area Counties	
2020 Population	2,931,773
Behavioral Bed Need @ 30 Per 100,000 Population	879
Licensed Beds, 2018 (TN & MS)	1,152
Bed Need (Surplus) on Licensed Beds	(273)
Staffed Beds (TN and MS)	969
Bed Need (Surplus) on Staffed Beds (TN only)	(90)
PROJECTION FOR CY2022	
Combined Primary and Secondary Service Area Counties	
2022 Population	2,961,410
Behavioral Bed Need @ 30 Per 100,000 Population	888
Licensed Beds, 2018 (TN & MS)	1,152
Bed Need (Surplus) on Licensed Beds	(264)
Staffed Beds (TN and MS)	969
Bed Need (Surplus) on Staffed Beds (TN only)	(81)

Source: Population data from Table Need-State Health Plan-Standard 1B on following page. Bed numbers are from Joint Annual Reports and Mississippi State Plan.

Notes on Bed Counts

- 1. PSA licensed beds in 2016 (744) plus 2017 additions of 6 beds at Crestwyn and 16 and Behavioral Health Center at Memphis = 766 licensed beds for Shelby County currently.
- 2. PSA staffed beds in 2016 (610) plus addition of presumably staffed 6 beds at Crestwyn and 16 at Behavioral Health currently = 632 staffed beds for Shelby County currently.
- 3. SSA licensed beds (386) are not known by the applicant to have changed since 2016.
- 4. SSA staffed beds (337) are not known by the applicant to have changed since 2016.

County PSA County Shelby SSA Counties (25)		2018	80			2020				2022	2	
PSA County Shelby SSA Counties (25)	0-17	18-64	+99	Total	0-17	18-64	+59	Total	0-17	18-64	+99	Total
Shelby SSA Counties (25)												
SSA Counties (25)	249,747	595,076	125,389	970,212	252,312	593,476	135,234	981,022	254,626	590,155	144,987	989,768
Benton	3,045	9,335	4,331	16,711	2,977	9,196	4,568	16,741	2,915	866'8	4,824	16,737
Carroll	6,105	16,308	6,340	28,753	950'9	16,057	699'9	28,782	6,077	15,832	686'9	28,898
Chester	3,913	11,326	3,394	18,633	3,880	11,508	3,590	18,978	3,908	11,544	3,844	19,296
Crockett	3,570	8,480	2,932	14,982	3,554	8,447	3,079	15,080	3,575	8,353	3,239	15,167
Decatur	2,410	6,527	3,092	12,029	2,372	6,442	3,263	12,077	2,369	6,404	3,484	12,257
Dyer	9,316	23,052	7,239	39,607	608'6	22,926	7,637	39,872	9,324	22,725	8,076	40,125
Fayette	9,859	26,864	9,885	46,608	10,014	27,325	11,171	48,510	10,058	27,528	12,542	50,128
Gibson	12,372	29,768	9,794	51,934	12,397	29,786	10,255	52,438	12,246	29,693	10,673	52,612
Hardeman	5,270	17,125	4,889	27,284	5,143	16,964	5,171	27,278	5,023	16,841	5,396	27,260
Hardin	5,290	15,053	6,337	26,680	5,204	14,898	6,681	26,783	5,170	14,690	2,006	26,866
Haywood	4,284	10,647	3,343	18,274	4,178	10,306	3,644	18,128	4,063	10,047	3,864	17,974
Henderson	688'9	17,382	5,565	29,836	868'9	17,441	5,959	30,298	096'9	17,485	6,307	30,752
Henry	6,846	18,487	8,438	33,771	6,777	18,319	8,959	34,055	6,720	18,160	9,454	34,334
Lake	1,207	5,897	1,337	8,441	1,187	5,993	1,399	8,579	1,147	6,070	1,484	8,701
Lauderdale	6,631	17,975	4,324	28,930	6,580	18,028	4,578	29,186	6,524	18,100	4,796	29,420
McNairy	5,921	15,605	2,960	27,486	5,860	15,572	6,328	27,760	5,796	15,549	6,685	28,030
Madison	25,039	62,214	17,546	104,799	25,201	62,208	18,943	106,352	25,487	62,090	20,326	107,903
Obion	904'9	18,348	6,571	31,625	6,619	18,043	6,897	31,559	6,584	17,727	7,171	31,482
Tipton	16,996	42,277	996'6	69,239	17,157	42,995	11,044	71,196	17,294	43,822	12,025	73,141
Weakley	7,017	22,513	6,770	36,300	6,975	22,266	7,119	36,360	7,025	21,869	7,438	36,332
TN SSA Subtotal	398,433	990,259	253,442	1,642,134	400,650	988,196	272,188	1,661,034	402,891	983,682	290,610	1,677,183
Critenden (AR)	13,203	29,694	6,323	49,402	12,713	29,557	6,587	49,039	12,346	29,454	6,785	48,675
Lawrence (AR)	3,692	9,754	3,396	16,905	3,601	9,641	3,476	16,780	3,533	9,556	3,536	16,656
DeSoto (MS)	46,645	108,832	21,432	174,134	47,316	112,145	22,996	179,683	47,819	114,630	24,169	185,231
Marshall (MS)	7,677	22,612	5,726	36,138	7,368	22,365	6,035	35,891	7,136	22,180	6,267	35,645
Benton (MS)	1,897	5,075	1,389	8,397	1,818	5,097	1,373	8,324	1,759	5,114	1,361	8,252
AR/MS SSA Subtotal	73,114	175,967	38,266	284,976	72,816	178,805	40,467	289,717	72,593	180,934	42,118	294,459
SSA Total	471,547	1,166,226	291,708	1,927,110	473,466	1,167,001	312,655	1,950,751	475,484	1,164,616	332,728	1,971,642
PSA + SSA Total	721,294	1,761,302	417,097	2,897,322	725,778	1,760,477	447,889	2,931,773	730,110	1,754,771	477,715	2,961,410
MONTH OF PORT A SOL				7 700				204 3				296 9
SSA Need @ 30/100K				578.1		Ì		585.2				591.5
Total Need @ 30/100K				869.2				879.5				888.4

Sources: (1) The University of Tennessee Center for Business and Economic Research, Population Projection Data Files.

Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment.

(2) ACS Demographic & Housing Estimates, 2010-2015 American Community Survey 5-year estimates, U.S. Census Bureau. Cohort totals for 2017-2021 developed from straight-line projection of 2010 & 2015 Census Bureau cohort totals.

Note: These data may not match the University of Tennessee data exactly due to rounding.

- 2. Additional Factors: An applicant shall address the following factors:
 - a. The willingness of the applicant to accept emergency involuntary and non-emergency indefinite admissions;

Response:

The applicant does accept emergency involuntary admissions.

b. The extent to which the applicant serves or proposes to serve the TennCare population and the indigent population;

Response:

In 2017, Crestwyn had a TennCare/Medicaid payor mix of approximately 46% and a charity care payor mix of approximately 1%.

c. The number of beds designated as "specialty" beds (including units established to treat patients with specific diagnoses);

Response:

There are no specialty bed unit designations at Crestwyn. There are four program divisions, two for adults, one for children (10-12) and adolescents, and one for dual diagnosis patients.

d. The ability of the applicant to provide a continuum of care such as outpatient, intensive outpatient treatment (IOP), partial hospitalization, or refer to providers that do;

Response:

The applicant has a strong and expanding continuum of inpatient and outpatient services. Inpatients after discharge typically enter a step-down Partial Hospitalization Program (PHP) 5 hours per day, 5 days per week. There is also an Intensive Outpatient Program (IOP) with three group sessions per day, which is conducted on either a 3-day or 5-day span of time. If discharged patients have personal or job-related conflicts with participating in the PHP program, they may enter the evening IOP program.

At the present time, Crestwyn is organizing and recruiting medical leadership for a post-discharge outpatient program focused exclusively on alcohol and drug issues. It is projected to begin in the Fall of this year.

e. Psychiatric units for patients with intellectual disabilities;

Response:

To be admitted, a patient must demonstrate sufficient cognitive abilities to participate in both individual and group therapy. The facility's psychiatrists and clinical

teams will make that judgment using a Behavioral Health Assessment, not an arbitrary IQ standard.

f. Free standing psychiatric facility transfer agreements with medical inpatient facilities;

Response:

Crestwyn is partnered with two co-owning general acute care hospital systems-Baptist and Saint Francis. Crestwyn has patient transfer agreements with both.

g. The willingness of the provider to provide inpatient psychiatric services to all populations (including those requiring hospitalization on an involuntary basis, individuals with co-occurring substance use disorders, and patients with comorbid medical conditions); and

Response:

The applicant provides short-term acute inpatient care to patients requiring hospitalization on an involuntary basis, and individuals with co-occurring substance abuse issues. It provides transfers to Baptist Hospital, for patients who require acute inpatient medical care.

h. The applicant shall detail how the treatment program and staffing patterns align with the treatment needs of the patients in accordance with the expected length of stay of the patient population.

Response:

The facility serves short-stay acute patients diagnosed with a psychiatric condition. 2017 average lengths of stay were 10.3 days overall. That was comprised of 10.5 days for adults, 10.8 days for patients 17 years of age or younger, and 8.0 days for dual diagnosis patients.

Excluding dual diagnosis patients, ALOS for all psychiatric programs averaged 10.5 days.

i. Special consideration shall be given to an inpatient provider that has been specially contracted by the TDMHSAS to provide services to uninsured patients in a region that would have previously been served by a state operated mental health hospital that has closed.

Response:

Not applicable to the primary service area or to this applicant.

j. Special consideration shall be given to a service area that does not have a crisis stabilization unit available as an alternative to inpatient psychiatric care.

Response:

The service area has two TennCare-designated Crisis Stabilization teams--Youth Villages and Alliance--both of which support this project.

3. Incidence and Prevalence: The applicant shall provide information on the rate of incidence and prevalence of mental illness and substance use within the proposed service area in comparison to the statewide rate. Data from the TDMHSAS or the Substance Abuse and Mental Health Services Administration (SAMHSA) shall be utilized to determine the rate. This comparison may be used by the HSDA staff in review of the application as verification of need in the proposed service area.

Rationale: The rate of incidence and prevalence of mental illness in the service area may indicate a need for a higher number of psychiatric inpatient beds in the designated area.

Response:

The applicant has consulted in the past with planning staff at the TDMHSAS, who knew of no source of such data that could be used to project need for inpatient psychiatric beds.

4. Planning Horizon: The applicant shall predict the need for psychiatric inpatient beds for the proposed first two years of operation.

Rationale: The Division believes that projecting need two years into the future is more likely to accurately reflect the coming trends and less likely to overstate potential future need.

Response:

Crestwyn's operational projections in this application extend to Year Five of the project's operation, which will be CY2023.

The response to Standard 1 in this section includes projected service area bed needs in CY2020 and CY2022, using the State Health Plan methodology.

5. Establishment of Service Area: The geographic service area shall be reasonable and based on an optimal balance between population density and service proximity of the applicant. The socio-demographics of the service area and the projected population to receive services shall be considered. The proposal's sensitivity and responsiveness to the special needs of the service area shall be considered, including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, other medically underserved populations, and those who need services involuntarily. The applicant may also include information on patient

origination and geography and transportation lines that may inform the determination of need for additional services in the region.

Applicants should be aware of the Bureau of TennCare's access requirement table, found under "Access to Behavioral Health Services" on pages 93-94 at http://www.tn.gov/assets/entities/tenncare/attachments/operationalprotocol.pdf.

Rationale: In many cases it is likely that a proposed psychiatric facility's service area could draw more significantly from only a portion of a county. When available, the Division would encourage the use of sub-county level data that are available to the general public (including utilization, demographic, etc.) to better inform the HSDA in making its decisions. Because psychiatric patients often select a facility based on the proximity of caregivers and family members, as well as the proximity of the facility, factors other than travel time maybe considered by the HSDA. Additionally, geography and transportation lines may limit access to services and necessitate the availability of additional psychiatric inpatient beds in specific service areas.

Response:

The applicant is an existing hospital with an established service area and payor mix, which are the basis for the application's projected service area and payor mix. These document Crestwyn's broad accessibility to the groups named in this standard. It would be inappropriate to project a different service area or payor mix, based on purely demographic and socio-economic data.

6. Composition of Services: Inpatient hospital services that provide only substance use services shall be considered separately from psychiatric services in a CON application; inpatient hospital services that address co-occurring substance use/mental health needs shall be considered collectively with psychiatric services. Providers shall also take into account concerns of special populations (including, e.g., supervision of adolescents, specialized geriatric, and patients with comorbid medical conditions).

This project will decrease the applicant's complement of dual diagnosis beds in response to experience with its admissions. However, the application complies with this standard by considering its psychiatric and dual diagnosis patients' needs collectively in application of planning methodologies.

The composition of population served, mix of populations, and charity care are often affected by status of insurance, TennCare, Medicare, or TriCare; additionally, some facilities are eligible for Disproportionate Share Hospital payments based on the amount of charity care provided, while others are not. Such considerations may also result in a prescribed length of stay.

Rationale: Because patients with psychiatric conditions often experience co-morbid conditions, it is important that providers be capable of addressing such patients' potential medical needs. The accessibility of psychiatric services to various

populations and for appropriate lengths of stay are important considerations for the HSDA when reviewing psychiatric inpatient services applications.

Response:

Crestwyn is accessible to all of these patient populations. Crestwyn is contracted with all three of its area's TennCare MCO's and also with Medicaid in other States. Services to TennCare and indigents are reflected in its payor mix and in its Projected Data Chart. Crestwyn's 10.3 day average length of stay is slightly below the average for Memphis psychiatric hospitals as reported in their 2016 JAR's (11.0) and well below the average length of stay for rural West Tennessee behavioral units and hospitals (23.0).

7. Patient Age Categorization: Patients should generally be categorized as children (0-12), adolescents (13-17), adults (18-64), or geriatrics (65+). While an adult inpatient psychiatric service can appropriately serve adults of any age, an applicant shall indicate if they plan to only serve a portion of the adult population so that the determination of need may be based on that age-limited population. Applicants shall be clear regarding the age range they intend to serve; given the small number of hospitals who serve younger children (12 and under), special consideration shall be given to applicants serving this age group. Applicants shall specify how patient care will be specialized in order to appropriately care for the chosen patient category.

Rationale: Based on stakeholder input, the Division has categorized the patient population into children, adolescents, adults, and geriatric. Each age category may require unique care.

Response:

This licensed and accredited facility provides distinct and appropriate care programs for all of the above age cohorts, except that it does not routinely serve children 12 years of age or younger. At the request of Youth Villages (The area's TennCare-designated crisis intervention organization) Crestwyn has admitted 10-12 year old children as special cases at TennCare's request, but not frequently. Ages 10-12 are considered "bridge years" between childhood and adolescence. Regulations do not prohibit children of that age rooming with an adolescent who is within two years of the child's age, if approved by the medical staff and the child's family.

8. Services to High-Need Populations: Special consideration shall be given to applicants providing services fulfilling the unique needs and requirements of certain high-need populations, including patients who are involuntarily committed, uninsured, or low-income.

Response:

Crestwyn serves all of these groups. Its payor mix last year was approximately 46% TennCare/Medicaid and 1% charity.

9. Relationship to Existing Applicable Plans; Underserved Area and Populations: The proposal's relationships to underserved geographic areas and underserved population groups shall also be a significant consideration. The impact of the proposal on similar services in the community supported by state appropriations shall be assessed and considered; the applicant's proposal as to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, shall also be assessed and considered. The degree of projected financial participation in the Medicare and TennCare programs shall be considered.

Response:

The primary and secondary service areas for Crestwyn have two State hospitals (Memphis; Bolivar) who are funded to serve primarily indigent and long-term stay patients. These are different patient populations from those served by other Shelby County behavioral hospitals. This project will not adversely impact them. They did not oppose Crestwyn's original application and they are not expected to be concerned about this bed addition proposal.

The applicant participates heavily in TennCare and Medicare. Last year its payor mix on gross revenues for those patients was approximately 46% and 23%, respectively--a total of 69%.

Relationship to Existing Similar Services in the Area: The proposal shall discuss what similar services are available in the service area and the trends in occupancy and utilization of those services. This discussion shall also include how the applicant's services may differ from existing services (e.g., specialized treatment of an age-limited group, acceptance of involuntary admissions, and differentiation by payor mix). Accessibility to specific special need groups shall also be discussed in the application.

Rationale: Based on stakeholder input, a number of factors, including occupancy, shall be considered in the context of general utilization trends. Additionally, several factors may be necessary to consider when determining occupancy including staffed beds verses licensed beds, the target patient population, and the operation of specialty units.

Response:

Trends in occupancy and utilization of other licensed mental health hospitals and psychiatric units of general hospitals are presented and discussed in Section B-Need-5 of the application. The applicant believes that in 2018, there are 969 staffed and available inpatient behavioral beds in the primary and secondary service area counties. The most recent utilization data for the Tennessee providers is CY 2016, when service area providers reported 839 staffed beds and 74.1% occupancy on staffed beds. See Section B-Need-5 for additional data on licensed beds, many of which are unavailable for patient care.

10. Expansion of Established Facility: Applicants seeking to add beds to an existing facility shall provide documentation detailing the sustainability of the existing facility. This documentation shall include financials, and utilization rates. A facility seeking approval for expansion should have maintained an occupancy rate for all

licensed beds of at least 80 percent for the previous year. The HSDA may take into consideration evidence provided by the applicant supporting the need for the expansion or addition of services without the applicant meeting the 80 percent threshold. Additionally, the applicant shall provide evidence that the existing facility was built and operates, in terms of plans, service area, and populations served, in accordance with the original project proposal.

Rationale: Based on stakeholder input, the implementation of an 80 percent threshold for the approval may serve as an indicator of economic feasibility for the expansion of the facility. The 80 percent occupancy requirement may limit an applicant's ability to add specialty services that require separation from other units. Examples include geriatric psychiatry, services for patients with co-occurring mental health needs and substance use disorders. Additionally, the majority of the programs in the state are currently operating under this threshold. The communities these programs serve may have needs that require an expansion of services. An applicant may provide evidence of the economic feasibility of expansion despite not operating at or above 80 percent of capacity.

Response:

Crestwyn is proposing to add only psychiatric beds; it is actually decreasing its dual diagnosis bed complement.

The CY2017 occupancy on the three psychiatric programs seeking to expand was 87.5%. The applicant has submitted historic financials (Historic Data Chart and its own financial statements) documenting that it has operated with a positive cash flow and a positive operating margin.

11. Licensure and Quality Considerations: Any existing applicant for this CON service category shall be in compliance with the appropriate rules of the TDH and/or the TDMHSAS. The applicant shall also demonstrate its accreditation status with the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or other applicable accrediting agency. Such compliance shall provide assurances that applicants are making appropriate accommodations for patients (e.g., for seclusion/restraint of patients who present management problems, and children who need quiet space). Applicants shall also make appropriate accommodations so that patients are separated by gender in regards to sleeping as well as bathing arrangements. Additionally, the applicant shall indicate how it would provide culturally competent services in the service area (e.g., for veterans, the Hispanic population, and LBGT population).

Response:

The applicant is licensed and accredited, and operates in compliance with all State and Federal rules. Appropriate age and gender separations are always observed. Seclusion rooms are provided. Services are provided with cultural sensitivity to all patients. Translation services are available telephonically.

12. Institution for Mental Disease Classification: It shall also be taken into consideration whether the facility is or will be classified as an Institution for Mental Disease (IMD). The criteria and formula involve not just the total number of beds, but the average daily census (ADC) of the inpatient psychiatric beds in relation to the ADC of the facility. When a facility is classified as an IMD, the cost of patient care for Bureau of TennCare enrollees aged 21-64 will be reimbursed using 100 percent state funds, with no matching federal funds provided; consequently, this potential impact shall be addressed in any CON application for inpatient psychiatric beds.

Response:

This hospital has an IMD classification. The project will expand child and adolescent bed complements while reducing total adult services (net difference in bed changes for the adult psychiatric and dual diagnosis programs). So the project will not adversely affect TennCare's cost-sharing with Federal Medicaid.

13. Continuum of Care: Free standing inpatient psychiatric facilities typically provide only basic acute medical care following admission. This practice has been reinforced by Tenn. Code Ann. § 33-4-104, which requires treatment at a hospital or by a physician for a physical disorder prior to admission if the disorder requires immediate medical care and the admitting facility cannot appropriately provide the medical care. It is essential, whether prior to admission or during admission, that a process be in place to provide for or to allow referral for appropriate and adequate medical care. However, it is not effective, appropriate, or efficient to provide the complete array of medical services in an inpatient psychiatric setting.

Response:

Crestwyn has transfer agreements in place with Baptist and St. Francis Hospitals, for the care of such patients with medical conditions that cannot be cared for at Crestwyn.

14. Data Usage: The TDH and the TDMHSAS data on the current supply and utilization of licensed and CON-approved psychiatric inpatient beds shall be the data sources employed hereunder, unless otherwise noted. The TDMHSAS and the TDH Division of Health Licensure and Regulation have data on the current number of licensed beds. The applicable TDH JAR provides data on the number of beds in operation. Applicants should utilize data from both sources in order to provide an accurate bed inventory.

Rationale: Using these sources for data is the only way to ensure consistency across the evaluation of all applications. Data provided by the TDH and the TDMHSAS shall be relied upon as the primary sources of data for CON psychiatric inpatient services applications. Each data source has specific caveats. Requiring the use of both licensed beds and operating beds will provide a more comprehensive bed inventory analysis.

Response:

The statistical data required for this application have been obtained from the Tennessee Department of Health's most current county-level population projections, Licensure reports, and Joint Annual Reports. The applicant is not aware that additional bed utilization data from TDMHSAS is needed for this particular project.

15. Adequate Staffing: An applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed Service Area. Each applicant shall outline planned staffing patterns including the number and type of physicians. Additionally, the applicant shall address what kinds of shifts are intended to be utilized (e.g., 8 hour, 12 hour, or Baylor plan). Each unit is required to be staffed with at least two direct patient care staff, one of which shall be a nurse, at all times. This staffing level is the minimum necessary to provide safe care. The applicant shall state how the proposed staffing plan will lead to quality care of the patient population served by the project.

However, when considering applications for expansions of existing facilities, the HSDA may determine whether the existing facility's staff would continue without significant change and thus would be sufficient to meet this standard without a demonstration of efforts to recruit new staff.

Response:

This is an existing facility that conforms to the recommended staffing pattern. Crestwyn's nurses work 12-hour shifts (two per day) and its mental health techs (MHT) work 8-hour shifts (three per day). Units are always staffed with a minimum of 1 Nurse and 1 MHT per shift; and additional staff are utilized based on the acuity of the unit's census every day. For any patient who is at risk of harming him/herself or others, a dedicated MHT is assigned to be within arm's length of that patient 24/7 hat patient 24/7 at arm's length. The staffing table in Section B-Economic Feasibility-8 documents staffing projected for the facility.

16. Community Linkage Plan: The applicant shall describe its participation, if any, in a community linkage plan, including its relationships with appropriate health care system providers/services and working agreements with other related community services assuring continuity of care (e.g., agreements between freestanding psychiatric facilities and acute care hospitals, linkages with providers of outpatient, intensive outpatient, and/or partial hospitalization services). If they are provided, letters from providers (e.g., physicians, mobile crisis teams, and/or managed care organizations) in support of an application shall detail specific instances of unmet need for psychiatric inpatient services. The applicant is encouraged to include primary prevention initiatives in the community linkage plan that would address risk factors leading to the increased likelihood of Inpatient Psychiatric Bed usage.

Rationale: The Division recognizes that participation in community linkage plans is an important element in the provision of quality psychiatric inpatient services; therefore, it is important for applicants to demonstrate such connections with other community providers. The 2014 update to the State Health Plan moved from a primary emphasis of health care to an emphasis on "health protection and promotion". The development of primary prevention initiatives for the community advances the mission of the State Health Plan.

These linkages have been discussed in several responses to these standards and elsewhere in the application.

This application has received many strong support letters from community agencies and individuals who see the need for additional inpatient beds for troubled patients--especially younger persons (for whom this project will double Crestwyn's assigned bed complement). Their letters attest to Crestwyn's active involvement with their communities and their programs. Please read their letters in the Attachments to this document. Letters of support have been received from the following organizations and individuals thus far.

- 1. Youth Villages and Alliance Healthcare Services--These two organizations provide rapid-response assessment, evaluation, stabilization, and referral of children and adolescents who are experiencing a psychiatric emergency. They are the two designated resources for TennCare in the regional project service area, and have strong and continuing relationships with Crestwyn.
- 3. NAMI (National Alliance on Mental Illness)--a grass-roots advocacy organization dedicated to improving quality of life for persons with severe and persistent mental illness, and their families and communities. NAMI
- 4. Professional Care Services of West Tennessee--an agency of caring professionals who respond to mental health needs of their communities through assessment, intervention, treatment, rehabilitation, and support. PCS's six regional offices provide a broad range of outpatient services to adults and to children. They have multiple types of professionals available for their patients.
- 5. Serenity Recovery Centers--well-established across the Mid-South, this organization is one of the largest and most trusted names in assisting people with co-occurring disorders, and addictions. The Centers serve more than 700 persons annually.
- 6. Quinco Community Mental Health (Jackson)--an outpatient treatment resource for individuals with addiction problems.
- 7. First Step Recovery Centers -- a nonprofit organization licensed by TDMHSAS.
- 8. Rep. Mark White, 83rd District, Tennessee General Assembly
- 9. Germantown Police Department
- 10. Bellevue Baptist Church

- 11. Revelation of Hope Counseling Services
- 12. Delta Medical Center
- 17. Access: The applicant must demonstrate an ability and willingness to serve equally all of the patients related to the application of the service area in which it seeks certification. In addition to the factors set forth in HSDA Rule 0720-11-.01(1) (listing the factors concerning need on which an application may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is limited access in the proposed service area.

Response:

The applicant's historic payor mix documents its accessibility to the general patient population, including low-income and elderly persons, and patients needing involuntary confinement.

18. Quality Control and Monitoring: The applicant shall identify and document its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system. An applicant that owns or administers other psychiatric facilities shall provide information on their surveys and their quality improvement programs at those facilities, whether they are located in Tennessee or not.

Rationale: This section supports the State Health Plan's Fourth Principle for Achieving Better Health regarding quality of care.

Response:

Crestwyn and Acadia (one of its three owners and the managing entity) have robust and effective quality improvement programs that include outcome and process monitoring systems. Please see the Attachments for examples.

The applicant is a joint venture that does not own any other psychiatric facilities in the State. The Attachments include Crestwyn's accreditation surveys and licensure surveys.

19. Data Requirements: Applicants shall agree to provide the TDH, the TDMHSAS, and/or the HSDA with all reasonably requested information and statistical data related to the operation and provision of services at the applicant's facility and to report that data in the time and format requested. As a standard of practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

Response:

The applicant so agrees.

(CONCLUSION OF RESPONSES TO STATE HEALTH PLAN CRITERIA FOR SECTION B)

(SECTION B APPLICATION FORM QUESTIONS, CONTINUED)

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any, and how it relates to previously approved projects of the applicant.

Crestwyn was organized as a joint enterprise between Acadia Healthcare and the Baptist and Saint Francis health systems of Memphis. They both strongly support Crestwyn's programs. Their jointly-owned facility received CON authorization to serve all age groups--adults, children, and adolescents. It was constructed with room to expand its bed complements without additional internal construction that could disrupt patient care in such a small facility.

After approximately one and a half years of operation, Crestwyn finished CY2017 with more than 86% occupancy on its adult psychiatric beds and more than 88% on its adolescent beds. In January 2018, the two programs combined operated at 98% occupancy.

However, its dual diagnosis admissions (patients with both psychiatric and substance abuse treatment needs) have not been as strong (33% occupancy in CY2017).

Crestwyn's five-year plan for this project therefore envisions re-assigning 5 dual diagnosis beds to its two psychiatric programs, and increasing the total facility complement by 14 beds. This will allow the dual diagnosis beds to operate at high efficiency (almost 87% in Year Four, CY2022). It will provide room for program growth in adult and adolescent programs, which are currently full and are turning away admissions requests for lack of bed availability. With demand trends continuing, Crestwyn anticipates reaching overall 82% occupancy in Year Two of this project (2020) and 90% occupancy in Year Five (2023).

So this application, which proposes to more completely utilize floor space that already exists, will help Crestwyn, and its partners at Baptist and Saint Francis, serve the patients their joint enterprise was approved to serve.

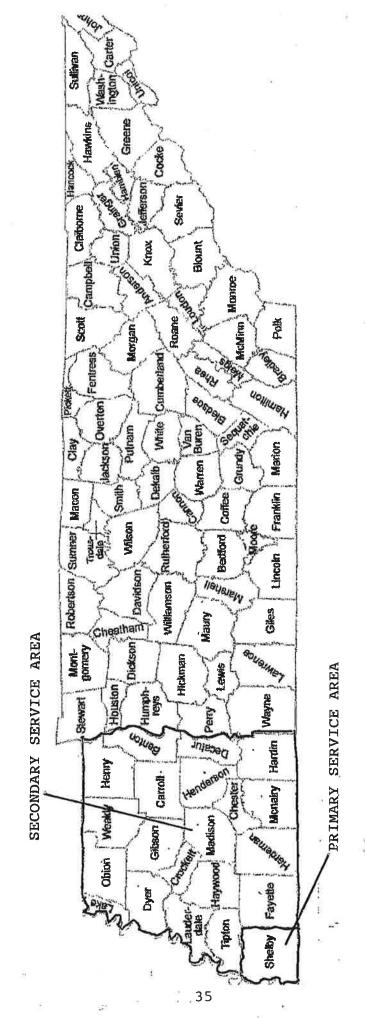
3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map for the Tennessee portion of the service area, using the map on the following page, clearly marked to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the bordering states, if applicable.

Crestwyn's original application in CY2015 projected a regional service area comprised of 68 counties in 3 States--with 86% of its admissions coming from 20 counties (10 Tennessee counties, 4 Mississippi counties, and 6 Arkansas counties).

In its first year of operation, Crestwyn's service area has been extensive. Approximately 95% of its patients came from 63 counties in three States. However, approximately 60% are from Shelby County, and no other county contributes more than approximately 3%; most are 1% or less of admissions. Therefore with HSDA staff consent, Shelby County is being declared as the applicant's primary service area ("PSA") with a large number of other counties being included as secondary service area ("SSA") counties. Knox, Davidson, and Rutherford Counties contribute 9-11 annual admissions as well, but they generate less than 1% of admissions and are too distant to be declared within a contiguous secondary service area.

Tab	le A-3A(3)(a): Service Area (V	West TN and MS/AR)
	Primary Service	Area
	Shelby Count	у
	Secondary Service Area	a Counties
Benton	Dyer	Lake
Benton MS	Fayette	Lauderdale
Carroll	Gibson	Lawrence AR
Chester	Hardeman	Madison
Crittenden AR	Hardin	Marshall MS
Crockett	Haywood	McNairy
Decatur	Henderson	Obion
Desoto MS	Henry	Tipton

Based on first year patient origin at Crestwyn there will also be referrals from counties and States beyond these areas, comprising approximately 13% of admissions. Please see the patient origin table following the service area map.



COUNTY (103)	STATE	Admissions	Cumulative Facility Admissions	County % of All Admissions	Cumulative % of All Admissions
Shelby	TN	790	790	59.5%	59.5%
Tipton	TN	41	831	3.1%	62.6%
Madison	TN	31	862	2.3%	64.9%
Crittenden	TN	25	887	1.9%	66.8%
Carroll	TN	22	909	1.7%	68.4%
Gibson	TN	21	930	1.6%	70.0%
Lauderdale	TN	21	951	1.6%	71.6%
Marshall	TN	15	966	1.1%	72.7%
Fayette	TN	11	977	0.8%	73.6%
Knox	TN	11	988	0.8%	74.4%
Benton	TN	10	998	0.8%	75.2%
Davidson	TN	10	1,008	0.8%	75.9%
McNairy	TN	10	1,018	0.8%	76.7%
Weakley	TN	10	1,028	0.8%	77.4%
Dyer	TN	9	1,037	0.7%	78.1%
Hardeman	TN	9	1,046	0.7%	78.8%
Rutherford	TN	9	1,055	0.7%	79.4%
Henry	TN	8	1,063	0.6%	80.0%
Lawrence	TN	8	1,071	0.6%	80.6%
Putnam	TN	8	1,079	0.6%	81.3%
Crockett	TN	7	1,086	0.5%	81.8%
Henderson	TN	7	1,093	0.5%	82.3%
Maury	TN	6	1,099	0.5%	82.8%
Montgomery	TN	6	1,105	0.5%	83.2%
Obion	TN	6	1,111	0.5%	83.7%
78 Other <0.5%	TN & Other	217	1,328	16.3%	
TOTAL	1	1,328			

Source: Hospital Management

3. (Continued) Please complete the following tables, if applicable:

	Applicant's Current	
Primary Service Area	Utilization From County	% of Applicant's Utilization
Counties	(2016-17 Admissions)	from County
Shelby	790	59.5%

	Projected Admissions To	
TN Primary Service Area	The Project in	
Counties	CY2019 (Year Two)	% of Total Admissions
Shelby	1,365	60%

4A(1). Describe the demographics of the population to be served by the proposal.

The second following page is additional demographic information on both the primary and secondary service area counties, in the format requested by HSDA projecting population growth to 2020. Its target population is the entire population because this applicant has been authorized to serve children, adolescent, and adult patients as bed space and appropriate treatment programs are available. Crestwyn has not yet admitted significant numbers of patients younger than 12, but intends to develop programs and facilities to serve more of those very young patients after Year Two of the project.

The demographic table on the following page shows these projections for the primary and secondary service areas of the project:

- The median age of the total service area is higher than the Tennessee State average; but the median age of Shelby County, the primary service area, is much younger--35.1 compared to 38.5 Statewide and 40.3 for the entire service area including Shelby County.
- Population growth for Shelby County and for the entire service area is approximately half that of Tennessee's.
- Shelby County, compared to the State of Tennessee, has apaproximately the same median income, but the service area as a whole has a significantly lower median income than the State's.
- Shelby County, the PSA, has a much higher percent of residents in TennCare/Medicaid, than does Tennessee: 26.5% compared to 21.2%. Shelby County has 21.4% of its residents living in poverty compared to 17.2% Statewide.

4A(2). Using current and projected population data from the Department of Health, the most recent enrollee data from the Bureau of TennCare, and demographic information from the U.S. Census Bureau, complete the following table and include data for each county in your proposed service area.

Projected Population Data:

http://www.tn.gov/health/article/statistics-population

TennCare Enrollment Data:

http://www.tn.gov/tenncare/topic/enrollment-data

Census Bureau Fact Finder:

http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Please see the table on the following page, which is compiled from these required sources.

Cur To Bary Service Area Popu Counties 20 PSA 9					2018-2020							
Cul Tr Tries Popi aties 20		Department of	Department of Health / Health Statistics	th Statistics				Bureau of the Census	he Census		TennCare	
	t Projected Total on Population	Total Population % n Change 2018 -	Current Target* Population All Ages	Projected Target* Population 2020	Projected Target* Population % Change	Projected Target* Population As % of Projected Total Population	Median Ane	Median Household Income	Persons Below Poverty Level as % of Total	Persons Below Poverty Level	Current TennCare	TennCare Enrollees as % of Total County or Zip Code
	212		1	981,022	1.1%	100.0%		\$46,854	21.4%	207,625	256,739	26.5%
			16 744	40.744	òc	90,007	200	E22 G44	708 00	4777	A 200	25.204
	752 20 707	0.2%		78782	0.2%	300.0%				5 693	7 738	26.9%
The start				18.978	1.9%	100.0%				3,335	3,980	21.4%
				15,080	%20	100.0%			18.3%	2,742	3,831	25.6%
				12,077		100.0%			20.9%	2,514	2,970	24.7%
Dyer		72 0.7%	39,607	39,872		100.0%		\$42,833	18.6%	7,367	10,690	27.0%
Ite		10 4.1%				100.0%	44.4		15.0%	6,991	7,065	15.2%
Gibson 51,934	934 52,438	38 1.0%			1.0%	100.0%			18.7%	9.712	13,058	25.1%
nar		%0.0						\$46,854	21.4%	5,839	7,021	25.7%
Hardin 26,680	680 26,783								22.2%	5,923	7,365	27.6%
Haywood 18,274	274 18,128	28 -0.8%							21.0%	3,838	5,567	30.5%
JU.				30,298					20.7%	6,176	7,348	24.6%
Henry 33,771					%8'0			\$38,378	19.4%	6,558	7,977	23.6%
Lake 8,4									29.2%	2,465	2,197	26.0%
ale									24.7%	7,146	7,834	27.1%
McNairy 27,486				27,760					23.1%	6,425	7,350	26.7%
Madison 104,799				Ì					19.4%	20,331	28,841	27.5%
Obion 31,625		59 -0.2%	31,625	31,559	-0.2%				21.1%	6,710	8,131	25.7%
Tipton 69,239						100.0%			13.8%	9,555	13,526	19.5%
Weakley 36,300					0.2%		37.5		19.1%	6,933	7,243	20.0%
Crittenden (AR) 49,402	402 49,039			49,039	%2.0-				24.6%	12,153	Па	na
Lawrence (AR) 16,905	905 16,780			16,780	%2.0-	100.0%			23.6%	4,026	па	na
DeSoto (MS) 174,134	134 179,683		-	179,683	3.2%	100.0%	36.2			17,413	na	na
Marshall (MS) 36,138	.,	91 -0.7%	(1)	35,891		100.0%		\$40,958		6,577	na	па
				8,324						1,906	na	na
			Ш	969,729	1.3%				19.7%	379,730	420,677	24.9%
State of TN Total 6,960,524 7,112,424 2.2% 6,960,524	524 7,112,424	24 2.2%	6,960,524	7,112,424	2.2%	100.0%	38.5	\$46,574	17.2%	1,197,210	1,476,375	21.2%

Sources: TDOH Population Projections, 2015; U.S. Census QuickFacts; TennCare Burea Service area data are either total, or average, as appropriate.

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4B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

This project's primary service area, from which 60% of its patients come, has a younger population, considerably more poverty, and a higher percentage of its population enrolled in TennCare than does the State of Tennessee overall. This project, by increasing the number of beds available to adolescents and some children, reflects the greater need of the primary service area for services to youth.

Crestwyn is very accessible to the elderly, women, racial or ethnic minorities, and low-income groups. Having more beds available at Crestwyn for all of these and other area residents will increase their access to the kind of care that is supported by community-based agencies across the service area. Thosse agencies working in the field have written favorably of the need for this project, so that the accessibility their clients have had to Crestwyn can continue.

5. Describe the existing and approved but unimplemented services of similar healthcare providers in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. List each provider and its utilization and/or occupancy individually. Inpatient bed projects must provide the following data: admissions or discharges, patient days, average length of stay, and occupancy. Other projects should use the appropriate measures, e.g., cases, procedures, visits, admissions, etc. This does not apply to projects that are solely relocating a service.

The acute inpatient psychiatric care providers in the project's primary service area are listed below. The maps on the following pages show their locations, keyed to their numbers on the list. After the maps is a two-page table showing their available beds and utilization data for CY2013-CY2016. This table excludes facilities not filing a Joint Annual Report but notes to the table identify recent licensed bed additions. Current utilization data for the sole out-of-State provider in the service area is not available to the applicant.

Shelby County

- 1. Behavioral Healthcare Center at Memphis *(new last year)* 1505 North Second Street, Memphis, TN 38107
- 2. Crestwyn Behavioral Health

9485 Crestwyn Hills Cove, Memphis, TN 38125

3. Delta Medical Center

3000 Getwell Road, Memphis, TN 38118

- 4. Lakeside Behavioral Health
 - 2911 Brunswick Road, Memphis, TN 38133
- 5. Memphis Mental Health Institute (State Hospital)

951 Court Avenue, Memphis, TN 38103

6. Methodist Healthcare

1265 Union Avenue, Memphis, TN 38104

7. St. Francis Hospital

5959 Park Avenue, Memphis, TN 38119

Other West Tennessee Counties

- 8. Baptist Memorial Huntingdon Hospital (Carroll County)
 - 631 R.B. Wilson Drive, Huntingdon, TN 38344
- 9. Behavioral Healthcare Center at Martin (Weakley County)

458 Hannings Lane, Martin, TN 38237

- 10. Henry County Medical Center (Henry County)
 - 301 Tyson Avenue, Paris, TN 38242
- 11. Pathways of Tennessee (Madison County)

238 Summar Drive, Jackson, TN 38301

12. Western Mental Health Institute (State Hospital) (Hardeman County)

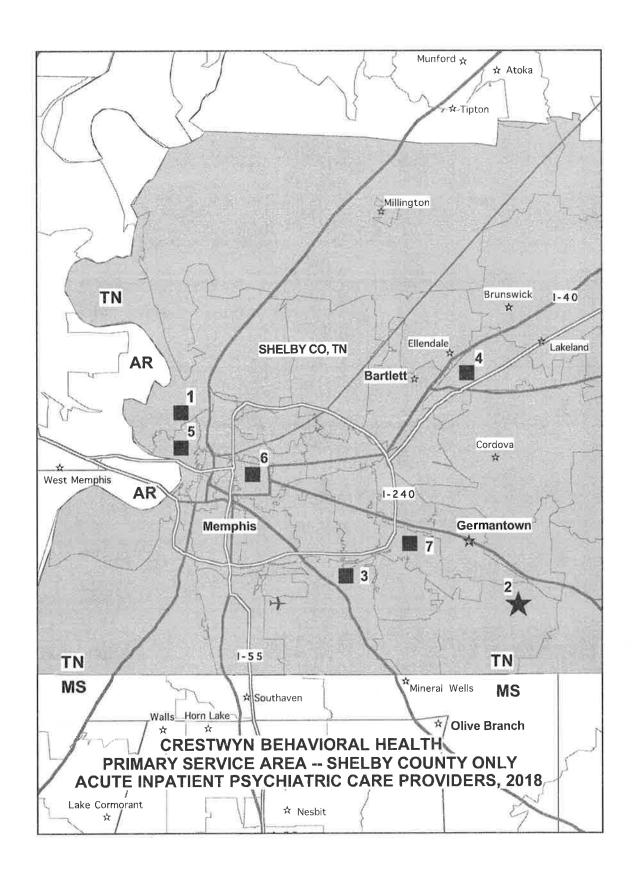
11100 Old Highway 643 West, Bolivar, TN 38008

13. Woodridge of West TN dba Oak Hills Behavioral Center (Madison County)

49 Old Hickory Boulevard, Jackson, TN 38305

Mississippi (No facilities in Arkansas Secondary Service Area)

Parkwood Behavioral Health (DeSoto County)
 8135 Goodman Road, Olive Branch, MS 38654



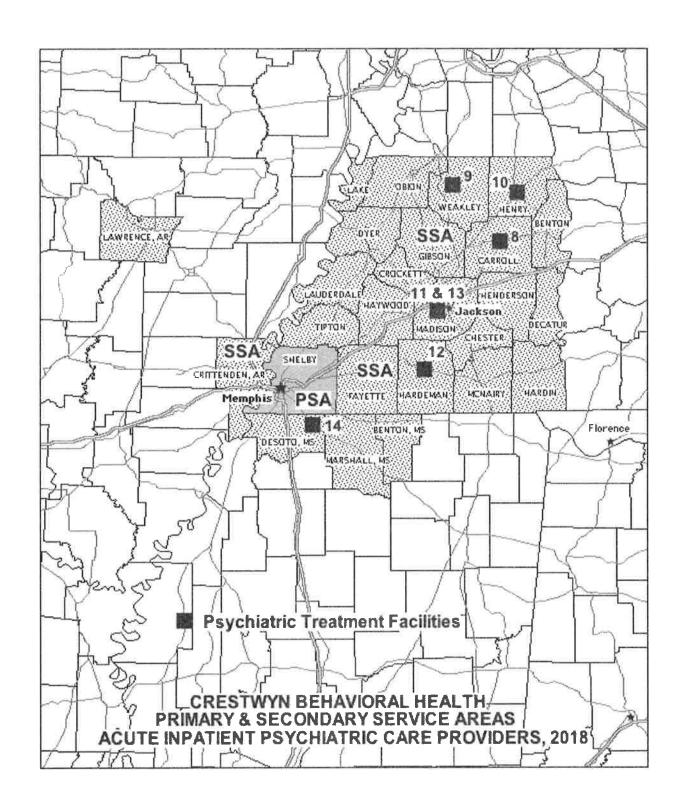


Table Need-5 (Page 1):	Psychiatr		lization ir 4-2016	n Crestwy	n's Tenne	essee Sei	vice Are	a	
2014 Joint Annual Reports of Hospitals									
	County	Staffed Psychiatric Beds	Assigned/ Licensed Psychiatric Beds	Behavioral Admissions	Behavioral Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds	Occupancy on Staffed Beds
Facility Name	Shelby	290	290	8,453	83,256	10	228	78.7%	78,7%
Lakeside Behavioral Health System Memphis Mental Health Institute	Shelby	55	55	1,565	16,877	11	46	84.1%	84.1%
Delta Medical Center	Shelby	109	109	2,873	37 501	13	103	94.3%	94.39
Methodist University Healthcarepsych beds	Shelby	34	34	441	8,467	19	23	68.2%	68.29
St. Francis Hospitalpsych beds	Shelby	102	102	1,384	11,502	8	32	30.9%	30.99
Primary Service Area (Shelby County) Subtotal		590	590	14716	157603	11	432	73.2%	73.2%
Western Mental Health Institute	Hardeman	150	187	1,012	43,483	43	119	63.7%	79.49
Henry Co Medical Center	Henry	22	22	214	2,189	10	6		27.39
Pathways of Tennesseepsych beds	Madison	25	25	706	3,706	5	10	40.6%	40,6%
Behavioral Healthcare Center at Martin	Weakley	16	16	231	4,274	19	12	73,2%	73,29
TN Secondary Service Area Subtotal		213	250	2,163	53,652	25	147	58.8%	69.0%
TN Primary & Secondary SA Totals		803	840	16,879	211,255	13	579	68.9%	72.1%
	210124111				100				
2015 Joint Annual Reports of Hospitals									
		Staffed Psychiatric	Assigned/ Licensed Psychiatric	Behavioral	Behavioral	Avg Length of Stay	Avg Daily Census	Occupancy on Licensed	Occupancy on Staffed
Facility Name	County	Beds	Beds	Admissions	Days	(Days)	(Patients)	Beds	Beds
Lakeside Behavioral Health System	Shelby	233	290	8,378	85,069	10	233		100.09
Memphis Mental Health Institute	Shelby	55	111	1,547	17,299	11	47	42.7%	86.29
Delta Medical Center	Shelby	109	109	2,875		13	101	92.3%	92.39
Methodist University Healthcarepsych beds	Shelby	34	34	388	7,791	20	21	62.8%	62.89
St. Francis Hospitalpsych beds	Shelby	102	102	1,502	13,825	9	38 440		37.19 82.69
Primary Service Area (Shelby County) Subtotal		533	646	14,690	160,725		440	00.2/0	02.07
Baptist Memorial Huntingdon Hospital	Carroll	12	12	148	1,871	13	5	42.7%	42.79
Western Mental Health Institute	Hardeman	150		1,046	46,855	45	128		85.69
Henry Co Medical Center	Henry	22	22	257	2,097	8	6		26.19
Pathways of Tennesseepsych beds	Madison	25	25	753	3,245	4	9		35.69
Behavioral Healthcare Center at Martin	Weakley	16		210		16			59.29
TN Secondary Service Area Subtotal		225		2,414		24	158		70.0%
TN Primary & Secondary SA Totals		758	908	17,104	218,248	13	598	65.9%	78.9%
								A CONTRACTOR	
2016 Joint Annual Reports of Hospitals			Assigned/			Avg			
Facility Name	County	Staffed Psychiatric Beds	Licensed	Behavioral Admissions	Behavioral Days	Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds	Occupancy on Staffe Beds
Crestwyn Behavioral Health	Shelby	30				10		41.7%	83.49
Lakeside Behavioral Health Systempsych beds	Shelby	337	345	8,719	86,239	10	236	68.5%	70,19
Memphis Mental Health Institute	Shelby	55	111	1,522		12	48		87.59
Delta Medical Center	Shelby	114	114	2,530	33,748				
Methodist University Healthcarepsych beds	Shelby	34		370					
St. Francis Hospitalpsych beds	Shelby	40	80	1,457					80.89
Primary Service Area (Shelby County) Subtotal		610							
Baptist Memorial Huntingdon Hospital	Carroll	7						-	56.20
Western Mental Health Institute	Hardeman	150							91.5
Henry County Medical Center	Henry	22							
Pathways of Tennesseepsych beds	Madison	18							
Woodridge of W TN dba Oak Hills Behavioral Center	Madison	16							
Behavioral Healthcare Center at Martin	Weakley	16							
TN Secondary Service Area Subtota		229							
TN Primary & Secondary SA Totals	1	839	1,022	18,061	226,916	13	622	60.8%	74.19

Notes:

- 1. Crestwyn Behavioral Health Center was open approximately 8 months in 2016; occupancies on its beds calculated on 244 days.
- 2. 25 licensed beds are now occupied by SE Mental Health Center staff.
 3. Behavioral Healthcare Center at Memphis (1505 N. Second St) opened 16 beds in 2017; they are not yet reported in JAR data.
 4. St. Francis currently does not staff all of its reported psychiatric beds for psychiatric care.

	Table Need-5 (Page 2)	. Psychiatric be	u ounzadon	III Grestwy	II S IVIISSISS	ippi ac	IVICE AIC	A	
	2017								·
State	Facility Name	Gounty	City	Licensed Psychiatric Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupani on Licens Beds
	Perkwood Behavioral Health System	DeSoto	Olive Branch	108	na	19.0	na	ne	

Notes:
1. No Arkansas facilities in project service area.
2. Parkwood is the only psychlatric hospital in the primary service area. Mississippi does not publish utilization data more recent than 2013.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three years and the projected annual utilization for each of the two years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology <u>must include</u> detailed calculations or documentation from referral sources, and identification of all assumptions.

Historical Utilization

Crestwyn opened in the Spring of CY2016, and filled its beds rapidly. Table B-Need-6 on the following page provides its utilization by program, from May of 2016 through January of 2018.

In its first full year of operation, CY2017, Crestwyn experienced a remarkable average occupancy of 87.5% of its 49 psychiatric beds (all programs), and 33.3% occupancy of its dual diagnosis beds, for an overall occupancy of 73.5% ON 66 beds.

In January 2018, Crestwyn averaged 94.2% occupancy on its 49 psychiatric beds, and 79.3% overall (which included an underutilized dual diagnosis unit with only 36.2% occupancy.

All indicators are that while adding 14 more beds, Crestwyn also needs to increase its psychiatric bed complements (especially adolescent beds) while reducing the number of beds assigned to dual diagnosis patients. That is what this application proposes.

Projected Utilization

Table B-Need-6 also projects Crestwyn's utilization for CY2018 through CY2023, Year Five of the hospital after enlarging its complement to 80 beds.

Adult beds, heavily utilized at 86.9% in 2017, increased to 91.4% occupancy in early 2018. If this project is approved, Crestwyn expects 2018 admissions to be 12% above 2017, then to dip 5% in 2019 due to focusing of resources on the adolescent and outpatient programs, and then to increase 1% annually through 2023, Year Five of the increased bed complement.

Child and Adolescent beds, which surged to 100% occupancy in early 2018, are expected to see an admissions increase of 12.8% in 2018 (based on having new beds available by July 1), and then 50% higher admissions in 2019, followed by 10% growth in Year Two (2020) and then 3% for the next three years.

Dual diagnosis admissions are projected to increase from 235 admissions in 2017 to 282 in this year--an increase in 20% (but on small numbers). The following year, the projected increase will be 15%, and thereafter 10% annually for four more years.

Table Need-6:	Crestwyr		ral Health -2023	ı Utiliz	ation By	Prograi	n	
					Proje	cted		
	Last Year 2017	Jan '18 31 days	2018	Yr 1 2019	Yr 2 2020	Yr 3 2021	Yr 4 2022	Yr 5 2023
CRESTWYN TOTAL BEDS	66	66	66	80	80	80	80	80
Admissions	1,724	159	2,004	2,275	2,404	2,479	2,559	2,643
Days	17,714	1,622	20,043	22,749	24,022	24,737	25,493	26,294
ALOS on Admissions	10.3	10.2	10.0	10.0	10.0	10.0	10.0	9.9
ADC on Admissions	48.5	52.3	54.9	62.3	65,6	67.8	69.8	72.0
Occupancy on Admissions	73.5%	79.3%	83.2%	77.9%	82.0%	84.7%	87.3%	90.0%
Adult & Geri Psychiatric Beds	33	33	33	36	36	36	36	36
Admissions	995	89	1,149	1,092	1,103	1,114	1,125	1,136
Days	10,469	935	11,724	11,138	11,249	11,362	11,476	11,590
ALOS on Admissions	10.5	10.5	10.2	10.2	10.2	10.2	10.2	10,2
ADC on Admissions	28.7	30.2	32.1	30.5	30.7	31.1	31.4	31.8
Occupancy on Admissions	86.9%	91.4%	97.3%	84.8%	85.4%	86.5%	87.3%	88.2%
Child and Adolescent Beds	16	16	16	32	32	32	32	32
Admissions	494	49	573	859	945	973	1,002	1,032
Days	5,179	496	5,840	8,760	9,636	9,925	10,223	10,530
ALOS on Admissions	10.5	10.1	10.2	10.2	10.2	10.2	10.2	10.2
ADC on Admissions	14.2	16.0	16.0	24.0	26.3	27.2	28.0	28.8
Occupancy on Admissions	88.7%	100.0%	100.0%	75.0%	82.3%	85.0%	87.5%	90.1%
Alcohol and Drug Beds	17	17	17	12	12	12	12	12
Admissions	235	21	282	324	357	392	432	475
Days	2,066	191	2,479	2,851	3,136	3,450	3,795	4,174
ALOS on Admissions	8.8	9.1	8.8	8.8	8.8	8.8	8.8	8.8
ADC on Admissions	5.7	6.2	6.8	7.8	8.6	9.5	10.4	11.4
Occupancy on Admissions	33.3%	36.2%	40.0%	65.1%	71.4%	78.8%	86.6%	95.3%
	Last Year 2017	Jan 2018	2018	Yr 1 2019	Yr 2 2020	Yr 3 2021	Yr 4 2022	Yr 5 2023
Combined Psychiatric Programs	2017	2010	2010	2019	2020	2021	2022	2025
Beds	49	49	49	68	68	68	68	68
Admits	1,489	138	1,722	1,951	2,048	2,087	2,127	2,169
Days	15.648	1,431	17,564	19,898	20,885	21,287	21,698	22,120
ALOS on Admissions	10.5	10.4	10.2	10.2	10.2	10.2	10.2	10.2
ADC on Admissions	42.9	46.2	48.1	54.5	57.2	58.3	59.4	60.6
Occupancy on Admissions	87.5%	94.2%	98.2%	80.2%		85.8%	87.4%	

Source: Hospital Management

ECONOMIC FEASIBILITY

- 1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.
- A. All projects should have a project cost of at least \$15,000 (the minimum CON Filing Fee), (See application instructions for Filing Fee.)
- B. The cost of any lease, The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.
- C. The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.
- D. Complete the Square Footage Chart on page 8 and provide the documentation. Please note the Total Construction Cost reported on line 5 of the Project Cost Chart should equal the Total Construction Cost reported on the Square Footage Chart.

See Attachment Section B-Economic Feasibility-1D.

- E. For projects that include new construction, modification, and/or renovation documentation must be provided from a licensed architect or construction professional that support the estimated construction costs. Provide a letter that includes the following:
 - 1) A general description of the project:
 - 2) An estimate of the cost to construct the project; and
 - 3) A description of the status of the site's suitability for the proposed project;
 - 4) Attesting the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities in current use by the licensing authority.

See Attachment Section B-Economic Feasibility-1E.

PROJECT COST CHART--CRESTWYN BEHAVIORAL HEAL--14 BED ADDITION

A. Construction and equipment acquired by purchase:

	1. 2. 3. 4. 5. 6. 7. 8.	Architectural and Engineering Fees Legal, Administrative, Consultant Fees (Excl Consultant Fees) Acquisition of Site Preparation of Site Total Construction Cost Contingency Fund Fixed Equipment (Not included in Construction Moveable Equipment (List all equipment over sas separate attachment) Other (Specify)	Contract) 550,000	5,000 50,000 0 0 0 0 21,000
В.	Aco	quisition by gift, donation, or lease:		
	1. 2. 3. 4. 5.	Facility (inclusive of building and land) Building only Land only Equipment (Specify) Other (Specify)		0 0 0 0
C.	Fin	ancing Costs and Fees:		
	1. 2. 3. 4.	Interim Financing Underwriting Costs Reserve for One Year's Debt Service Other (Specify)		0 0 0
D.		imated Project Cost -B+C)		76,000
E.	CO	N Filing Fee		15,000
F.	Tot	al Estimated Project Cost (D+E)	TOTAL \$	91,000
			ctual Capital Cost ection B FMV	91,000 0

2. Identify the funding sources for this project.

Check the applicable item(s) below and briefly summarize how the project will be financed. (Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)

A. Commercial LoanLetter from lending institution or guarantor stating tavorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;
B. Tax-Exempt Bondscopy of preliminary resolution or a letter from the issuing authority, stating favorable contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;
C. General Obligation BondsCopy of resolution from issuing authority or minutes from the appropriate meeting;
D. GrantsNotification of Intent form for grant application or notice of grant award;
_xE. Cash ReservesAppropriate documentation from Chief Financial Officer; or
F. OtherIdentify and document funding from all sources.

This very small project cost will be borne by the applicant hospital itself, using lines of credit available to it (see Long Term Debt on the balance sheet). Attachment B-Economic Feasibility-2 contains a letter from the Crestwyn Chief Financial Officer, committing to its availability. The hospital's income statement and balance sheet are provided in the Attachments to the application.

3. Complete Historical Data Charts on the following pages--Do not modify the Charts or submit Chart substitutions!

Historical Data Chart represents revenue and expense information for the last three (3) years for which complete data is available. Provide a Chart for the total facility and Chart just for the services being presented in the proposed project, if applicable. Only complete one chart if it suffices.

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

The Historical Data Chart for Crestwyn is provided on the following two pages.

HISTORICAL DATA CHART -- CRESTWYN BEHAVIORAL HEALTH

Give information for the last three (3) years for which complete data are available for the facility or agency. The fiscal year begins in January.

A.	Utilization Data	Admissions			CY 2016 (Partial) 656		CY 2017 1,724
	(Specify unit or measure)	Patient Days	v		6,360	_	17,714
В.	Revenue from Services to Patients						
	1. Inpatient Services		\$	\$	9,154,500	\$	26,569,500
	2. Outpatient Services			-	352,850	-	1,619,450
	3. Emergency Services			_	0	-	Q
	4. Other Operating Revenue		MINISTER STATES	-	281,275	-	480,792
	(Specify) See notes page			-			
		Gross Operating Revenue	\$0	- \$_	9,788,625	\$_	28,669,742
C.	Deductions from Gross Operating Rev	renue					
	1. Contractual Adjustments		\$	\$	6,221,933	\$	14,851,656
	2. Provision for Charity Care				54,504	-	329,869
	3. Provisions for Bad Debt			_	107,300		833,317
		Total Deductions	\$0	\$_	6,383,737	\$_	16,014,842
NET	OPERATING REVENUE		\$0	\$	3,404,888	\$_	12,654,900
D.	Operating Expenses						
	 Salaries and Wages 						
	a. Clinical		\$	\$	1,158,293	\$_	3,100,922
	b. Non-Clinical				1,663,783		2,563,678
	2. Physicians Salaries and Wages					_	0
	3. Supplies				298,487	-	438,481
	4. Rent						
	c. Paid to Affiliates		v			-	
	d. Paid to Non-Affiliates				19,152		44,375
	5. Management Fees						
	a. Paid to Affiliates			_		-	
	b. Paid to Non-Affiliates						
	6. Other Operating Expenses	See notes page.		_	2,150,639	-	4,817,896
		Total Operating Expenses	\$0	-	5,290,354	\$	10,965,352
E.	Earnings Before Interest, Taxes, and I	Depreciation	\$0	- \$_	(1,885,466)	\$_	1,689,548
F.	Non-Operating Expenses						
	1. Taxes		\$	_	278	-	
	2. Depreciation			-	539,828	-	831,996
	3. Interest		***************************************		912,469	-	936,757
	4. Other Non-Operating Expenses					-	(108,996)
	To	otal Non-Operating Expenses	\$0	- \$_	1,452,575	\$_	1,659,757
NET	INCOME (LOSS)		\$0	\$_	(3,338,041)	\$ 200	29,791
Cha	rt Continues Onto Next Page		51				

			NA	(CY 2016 (Partial)		CY 2017
NET	INCO	ME (LOSS)	\$	_ \$_	(3,338,041)	\$	29,791
G.	Oth	er Deductions					
	1.	Annual Principal Debt Repayment	\$	_ \$_	35,650	\$_	1,085,109
	2.	Annual Capital Expenditure			24,212,582		(493,440)
		Total Other Deductions	\$ 0	\$	24,248,232	\$_	591,669
		NET BALANCE	\$ 0	\$	(27,586,273)	\$_	(561,878)
		DEPRECIATION	\$	\$	539,827	\$_	831,995
		FREE CASH FLOW (Net Balance + Depreciation)	\$0	\$	(27,046,446)	\$_	270,117

X TOTAL FACILITY

O PROJECT ONLY

HISTORICAL DATA CHART - OTHER EXPENSES

OTH	HER EXPENSES CATEGORIES	NA	CY	2016 (Partial)		CY 2017
1.	Benefits	\$ 7	\$	505,005	\$	1,095,339
2.	Contract Labor			9,395	_	170,338
3.	Purchase Svcs			293,498	_	558,793
4.	Professional Fees			381,566	_	1,203,250
5.	Utilities			146,040		228,081
6.	Repairs and Maintenance			56,547		104,150
7.	Insurance Expense			401,264	_	169,405
8.	Marketing Expense			38,684	_	104,053
9.	Enterprise Growth		_	0		108,996
10.	Other Operating Expense			318,640		1,075,491
11.						
12.						
13.					_	
14			_		_	
15.						
	Total Other Expenses	\$ 0	\$_	2,150,639	\$	4,817,896

3. Complete Projected Data Charts on the following pages - Do not modify the Charts provided or submit Chart substitutions!

The Projected Data Chart requests information for the two years following the completion of the proposed services that apply to the project. Please complete two Projected Data Charts. One Projected Data Chart should reflect revenue and expense projections for the *Proposal Only* (i.e., if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility). The second Chart should reflect information for the total facility. Only complete one chart if it suffices.

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

PROJECTED DATA CHART -- CRESTWYN BEHAVIORAL HEALTH

Give information for the last three (3) years for which complete data are available for the facility or agency. The fiscal year begins in January.

The	fisca	I year begins in January.					
					CY 2019		CY 2020
					(Year One)		(Year Two)
A.	Util	ization Data	Admissions	_	2,275	-	2,404
	(Sp	ecify unit or measure)	Patient Days	-	22,749	_	24,022
В.	Rev	enue from Services to Patients					
	1.	Inpatient Services		\$	36,898,878	\$_	40,140,762
	2.	Outpatient Services		-	2,614,500		2,745,225
	3.	Emergency Services		_		_	
	4.	Other Operating Revenue			24,000		25,200
		(Specify) See notes page					
			Gross Operating Revenue	\$_	39,537,378	\$_	42,911,187
C.	Dec	luctions from Gross Operating Re	venue				
o.	1.	Contractual Adjustments	Vollac	\$	21,859,527	\$	24,122,228
	2.	Provision for Charity Care		-	395,134	Ψ	428,860
	3.	Provisions for Bad Debt		-			
	Э.	Frovisions for Bau Debt	Tatal Dadwettan	_	790,268		857,720
NET	0.DE1	ATNO DEL CALLE	Total Deductions	> -	23,044,928	, a	25,408,807
		RATING REVENUE		\$	16,492,450	\$_	17,502,380
D.		erating Expenses					
	1.	Salaries and Wages			4.054.500		4 070 047
		a. Clinical		\$	4,051,529	-	4,278,247
		b. Non-Clinical			2,835,244	-	2,948,653
	2.	Physicians Salaries and Wages		****		-	
	3.	Supplies		-	645,338	-	701,894
	4.	Rent					
		c. Paid to Affiliates		-		-	
		d. Paid to Non-Affiliates		-	58,433	-	63,554
	5.	Management Fees					
		a. Paid to Affiliates		_		_	
		b. Paid to Non-Affiliates				_	
	6.	Other Operating Expenses	See notes page	-	5,386,733	_	5,727,718
			Total Operating Expenses	\$_	12,977,276	\$_	13,720,065
Ε,	Ean	nings Before Interest, Taxes, and	Depreciation	\$_	3,515,174	\$_	3,782,315
F.	Non	-Operating Expenses					
	1.	Taxes		\$		\$	
	2.	Depreciation			860,768		865,630
	3.	Interest		-	944,126	-	972,450
	4.	Other Non-Operating Expenses				-	
		Т	otal Non-Operating Expenses	\$_	1,804,894	\$	1,838,080
NET	INCO	ME (LOSS)		\$	1,710,280	\$	1,944,235
		ntinues Onto Next Page		-		-	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,

				CY 2019		CY 2020
NET	INCO	ME (LOSS)	\$ _	1,710,280	\$	1,944,235
G.	Othe	er Deductions				
	1.	Annual Principal Debt Repayment	\$	1,085,109	\$	1,085,109
	2.	Annual Capital Expenditure		164,925		175,024
		Total Other Deductions	\$	1,250,034	\$	1,260,133
		NET BALANCE	\$	460,247	\$	684,103
		DEPRECIATION	\$_	860,768	\$	865,630
		FREE CASH FLOW (Net Balance + Depreciation)	\$_	1,321,015	\$_	1,549,733

X TOTAL FACILITY

0 PROJECT ONLY

PROJECTED DATA CHART -- OTHER EXPENSES

OTH	IER EXPENSES CATEGORIES	C	Y 2019	CY	2020
1.	Benefits	\$	1,409,877	\$1	,479,508
2.	Contract Labor	5			
3.	Purchase Svcs		754,747		820,890
4.	Professional Fees		1,377,159	1	,497,849
5.	Utilities		349,700		380,347
6.	Repairs and Maintenance		156,407		170,114
7.	Insurance Expense		198,904		204,871
8.	Marketing Expense		91,036		93,767
9.	Enterprise Growth	-	115,669	111	119,139
10.	Other Operating Expense		933,235	***************************************	961,232
11.				W-10	
12.					
13.					
14					
15.		_		**	
	Total Other Expenses	\$	5,386,733	\$ 5	,727,718

5.A. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please complete the following table.

	Project	Project			% Change
	Previous	Current	Project	Project	(Current
	Year	Year	Year One	Year Two	Yr to Yr2)
Gross Charge Gross Operating IP	\$16,630		\$17,379	\$17,850	+2.7%
Revenue / ADMISSION		NA			
Revenue / DAY	\$1,618		\$1,738	\$1,786	+2.8%
Deduction from Revenue Total	\$9,289		\$10,130	\$10,569	+4.3%
Deductions / ADMISSION		NA			
Deductions / DAY	\$904		\$1,013	\$1,058	+4.4%
Average Net Charge Net	\$7,340		\$7,249	\$7,281	+0.4%
Operating Rev / ADMISSION		NA			
Operating Rev / DAY	\$714		\$725	\$729	+0.6%

B. Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

The response to question 5C on the following page includes a table with current and projected charges for the most common DRG's at Crestwyn, together with the current Medicare reimbursement for each.

This project will not cause any charge increases at Crestwyn, because it involves a very small capital expenditure that will not create new debt service, and it will permit a significant revenue increase as space constraints on admissions are lifted by new bed capacity coming on line.

C. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Please see Table Economic Feasibility-5C on the following page for information about proposed charges at Crestwyn for frequent admissions DRG's

Below is a table comparing Crestwyn's projected 2019 charges to the 2016 charges reported in the Joint Annual Reports of other area facilities. There is not JAR revenue information specific to behavioral health units of general hospitals, so the table includes only behavioral health hospitals in the Tennessee service area.

Ta	ble Eco	nomic F	easibility-5C:	Charge Com	parisons	
Hospital	Year	IP Days	Gross IP Revenue	Net IP Revenue	Gross Rev. Per Day	Net Rev. Per Day
Lakeside Behavioral Health, Memphis	2016	78,173	\$165,878,934	\$62,122,510	\$2,122	\$795
Pathways of Tennessee, Jackson	2016	3,304	\$2,974,056	\$586,153	\$901	\$177
Woodridge/Oak Hills, Jackson	2016	3,475	\$5,179,776	\$2,609,444	\$1,491	\$751
Crestwyn Behavioral Health	2017	17,714	\$26,659,500	na	\$1,505	na
Crestwyn Behavioral Health	2019	22,749	\$36,898,878	na	\$1,622	na

Source: Joint Annual Reports, 2016 and application's Historic and Projected Data Charts. Note: Lakeside reported only total gross revenue that may include outpatient revenue.

		equent DRGs		Average Gross				Charge	
DRG	Descriptor		g Per liem wable		urrent Year 2018		Project r 1 2019		roject r 1 202
57	Degenrative nervous system disorders without mcc	\$	691	\$	1,575	\$	1,622	\$	1,671
776	Postpartum and post abortion diagnoses without O.R. procedure	\$	691	\$	1,575	\$	1,622	\$	1,671
880	Acute adjustment reaction and psychosocial dysfunction	\$	691	\$	1,575	\$	1,622	\$	1,671
881	Depressive neuroses	\$	691	\$	1,575	\$	1,622	\$	1,671
882	Neuroses except depressive	\$	691	\$	1,575	\$	1,622	\$	1,671
884	Organic disturbances and intellectual disability	\$	691	\$	1,575	\$	1,622	\$	1,671
885	Psychoses	\$	691	\$	1,575	\$	1,622	\$	1,671
886	Behavioral and developmental disorders	\$	691	\$	1,575	\$	1,622	\$	1,671
894	Alcholol, drug abuse or dependence	\$	691	\$	1,575	\$	1,622	\$	1,671
896	Alcohol, drug abuse or dependence w/o rehab therapy with mcc	\$	691	\$	1,575	\$	1,622	\$	1,671
897	Alcohol, drug abuse or dependence w/o rehab therapy without mcc	\$	691	\$	1,575	\$	1,622	\$	1,671

6.A. Discuss how projected utilization rates will be sufficient to support the financial performance. Indicate when the project's financial breakeven is expected and demonstrate the availability of sufficient cash flow until financial viability is achieved.

Crestwyn currently has a positive cash flow and a positive operating margin. This project requires no new debt service and is projected to lead to a significant increase in revenues, so the hospital will continue to have a positive cash flow and operating margin when the bed addition is implemented.

Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the project.

Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as <u>Attachment C</u>, <u>Economic Feasibility</u>. NOTE: Publicly held entities only need to reference their SEC filings.

See Attachment Section B-Economic Feasibility-6A.

B. Net Operating Margin Ratio – Demonstrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings before interest, Taxes, and Depreciation/Net Operating Revenue).

Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following table:

	2 nd Yr Previous to Current Yr	1 st Yr Previous to Current Yr	Current Yr	Projected Yr 1	Projected Yr 2
Net Operating					
Margin Ratio		0.134	.200	0.213	0.216

C. Capitalization Ratio (Long-term debt to capitalization) – Measures the proportion of debt financing in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: (Long-term debt/(Long-term debt + Total Equity (Net assets)) x 100).

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

Net Assets \$11,668,504 Long Term Debt \$15,827,658 \$27,496,162

15,827,658/27,496,162 = .5756

Source: Acadia Healthcare 10K for 2016 (audited)

7. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

Applicant's Pr	ojected Payor Mix, Year 1	
Payor Source	Projected Gross Operating Revenue	As a Percent of Total Revenue
Medicare/Medicare Managed Care	\$8,895,910	22.5%
TennCare/Medicaid	\$18,305,806	46.3%
Commercial/Other Managed Care	\$10,951,854	27.7%
Self-Pay	\$316,299	0.8%
Charity Care	\$355,836	0.9%
Other	\$711,673	1.8%
Total	\$39,537,378	100.0%

8. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTE) positions for these positions. Additionally, please identify projected salary amounts by position classifications and compare the clinical staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources.

See the staffing table on the following page, which provides this data.

Table P Projected Add	Veed-12: Cres	ble Need-12: Crestwyn Behavioral Health Additional Staff Required for 14-Bed Exp	le Need-12: Crestwyn Behavioral Health Additional Staff Required for 14-Bed Expansion	
	Existing FTEs	Projected FTEs	Average Annual Salary (Contractual	Areawide / Statewide
Position Classification	(NA)	(11.7)	Rate)	Average Salary
A. Direct Patient Care Positions				
Mental Health Tech (MHT)	37.80	41.60	\$29,120	\$20,170
Nurse (RN)	13.70	15.10	\$70,720	\$58,410
Recreational Therapist	5.24	9.00	\$50,000	\$40,110
Total Direct Patient Care Positions	56.74	62.70		
B. Non-Patient Care Positions				
U/M Coordinator	1.60	2.00	\$65,000	not available
Total Non-Patient Care Positions	1.60	2.00		
Total Employees (A + B)	58.34	64.70		
C. Contractual Staff	2.33	2.60		
Total Staff (A+B+C)	29.09	67.30		

Source: Crestwyn management.

- 9. Describe all alternatives to this project that were considered and discuss the advantages and disadvantages of each alternative, including but not limited to:
- A. Discuss the availability of less costly, more effective and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, justify why not, including reasons as to why they were rejected.

The benefit intended by the proposal is an increase in inpatient psychiatric beds desired by many mental health agencies supporting the project. The applicant does no know of any other behavioral health provider who is in a position to accomplish this in existing space, without construction and without delay.

B. Document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements.

The applicant is not proposing new construction.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (i.e., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, that may directly or indirectly apply to the project, such as transfer agreements or contractual agreements for health services.

Crestwyn has a patient transfer agreement with both Baptist Hospital and St. Francis Hospital. It is co-owned by subsidiaries of Baptist and Saint Francis Hospitals. It has a sister hospital, Delta Medical Center, located across Shelby County to the west. Cretwyn contracts with all three MCO's in the area.

2. Describe the effects of competition and/or duplication of the proposal on the health care system, including the impact to consumers and existing providers in the service area. Discuss any instances of competition or duplication arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

A. Positive Effects

Additional beds at Crestwyn will allow it to meet increasing demand for its inpatient services at almost no capital cost. The increased capacity will allow it to keep meeting the growing needs of Medicare, TennCare/Medicaid, indigent and self-pay patients who are almost 70% of the hospital's payor mix.

B. Negative Effects

Crestwyn does not believe that this small number of beds will have a significant adverse impact on other behavioral health providers in Shelby County, its primary service area. Between 2014 and 2016, JAR data indicate that patient days of psychiatric care provided by service area facilities increased from 211,255 to 226,916--a two-year increase of 15,661 patient days.

Crestwyn's 14 beds, even were they to be used to 100% capacity, would take only 5,110 patient days from the service area. That is only a third of the market growth that has occurred the past two years. So any impact the project may have on other providers is likely to be more than offset by short-term growth in community demand for this type of care.

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3.A Discuss the availability of an accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State of Tennessee licensing requirements and/or requirements of accrediting agencies such as the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities.

Crestwyn is an existing provider and is familiar with the requirements of Licensure and the Joint Commission. Crestwyn staffs its units in compliance with those and other standards. This project will not require a large addition of staff; they can be recruited when needed.

B. Verify that the applicant has reviewed and understands all licensing and/or certification as required by the State of Tennessee and/or accrediting agencies such as the Joint Commission for medical/clinical staff. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

The applicant so vefifies.

C. Discuss the applicant's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

Crestwyn has a total of twenty-five (25) students on campus at the present time. Clinical rotation agreements are in place with the following schools:

Southwest Tennessee Community College The University of Memphis Rhodes University Union University Christian Brothers University

These rotations are providing training for:

RNs Social Workers Therapist Case Managers Mental Health Techss 4. Identify the type of licensure and certification requirements applicable and verify that the applicant has reviewed and understands them. Discuss any additional requirements, if applicable. Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure: Mental Health Hospital, from Tennessee Department of Mental Health and Substance Abuse Services (currently licensed and in good standing)

Certification Type: Medicare and TennCare/Medicaid Certification (current)

Accreditation: Joint Commission (current)

A. If an existing institution, describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility and accreditation designation.

Crestwyn Behavioral Health is licensed in good standing, certified for both Medicare and Medicaid/TenCare, and accredited by the Joint Commission. Documentation is provided in the Attachments.

B. For existing providers, please provide a copy of the most recent statement of deficiencies/plan of correction and document that all deficiencies/findings have been corrected, by providing a letter from the appropriate agency.

See Attachment Section B-Orderly Development-4B.

- C. Document and explain inspections within the past three survey cycles which have resulted in any of the following state, federal, or accrediting body actions: suspension of admissions, civil monetary penalties, notice of 23- ore 90-day termination proceedings from Medicare or Medicaid/TennCare, revocation/denial of accreditation, or other similar actions.
- (1) Discuss what measures the applicant has or will put in place to avoid similar findings in the future.

- 5. Respond to all of the following and for such occurrences, identify, explain, and provide documentation:
- A. Has any of the following:
- (1) Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);
- (2) Any entity in which any person(s) or entity with more than 5% ownership (direct of indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%; and/or
- (3) Any physician or other provider of health care, or administrator employed by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%...
- B. Been subjected to any of the following:
- (1) Final Order or Judgment in a State licensure action;
- (2) Criminal fines in cases involving a Federal or State health care offense;
- (3) Civil monetary penalties in cases involving a Federal or State health care offense;
- (4) Administrative monetary penalties in cases involving a Federal or State health care offense;
- (5) Agreement to pay civil or monetary penalties to the Federal government or any State in cases involving claims related to the provision of health care items and services; and/or
- (6) Suspension or termination of participation in Medicare or Medicaid/TennCare programs;
- (7) Is presently subject of/to an investigation, regulatory action, or party in any civil or criminal action of which you are aware;
- (8) Is presently subject to a corporate integrity agreement.

6. Outstanding Projects:

- a. Complete the following chart by entering information for each applicable outstanding CON by applicant or share common ownership; and
- b. Provide a brief description of the current progress, and status of each applicable outstanding CON.

		Outstandii	ig Projects		
			Annual Prog	gress Report*	
CON Number	Project Name	Date Approved	Due Date	Date Filed	Expiration Date
CN					
Status:					
CN					
Status:				·	

* Annual Progress Reports – HSDA Rules require that an Annual Progress Report (APR) be submitted each year. The APR is due annually until the Final Project Report (FPR) is submitted (FPR is due within 90 ninety days of the completion and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

- 7. Equipment Registry -- For the applicant and all entities in common ownership with the applicant.
- a. Do you own, lease, operate, and/or contract with a mobile vendor for a Computed Tomography Scanner (CT), Linear Accelerator, Magnetic Resonance Imaging (MRI), and/or Positron Emission Tomographer (PET)?

No.

- b. If yes, have you submitted their <u>registration</u> to HSDA? If you have, what was the date of the submission?
- c. If yes, have you submitted their <u>utilization</u> to HSDA? If you have, what was the date of the submission?

	Date of HSDA	Date of Last
Facility	Registration	Utilization Submittal

QUALITY MEASURES

Please verify that the applicant will report annually using forms prescribed by the Agency, concerning continued need and appropriate quality measures as determined by the Agency pertaining to the Certificate of Need, if approved.

The applicant so verifies.

SECTION C: STATE HEALTH PLAN QUESTIONS

T.C.A. §68-11-1625 requires the Tennessee Department of Health's Division of Health Planning to develop and annually update the State Health Plan (found at http://www.tn.gov/health/topic/health-planning). The State Health Plan guides the State in the development of health care programs and policies and in the allocation of health care resources in the State, including the Certificate of Need program. The 5 Principles for Achieving_Better_Health are from the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Discuss how the proposed project will relate to the <u>5 Principles for Achieving Better Health</u> found in the State Health Plan.

1. The purpose of the State Health Plan is to improve the health of the people of Tennessee.

Both nationally and in the applicant's service area, there is a growing need for additional treatment resources for mental illness. Hospitals such as Crestwyn have an important role to play in the continuum of care for persons with treatment needs. Crestwyn's proposal for a small increase in bed complements, which will be of particular importance to its youth program, will help address this major health concern in the service area.

2. People in Tennessee should have access to health care and the conditions to achieve optimal health.

Crestwyn is an active and significant provider in its service area. It now faces continuous bed shortages which limit its services to the community. This project will improve access to behavioral health care in the West Tennessee region.

3. Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging economic efficiencies.

The project will provide needed bed capacity with great efficiency. Without the need for anything but furnishing patient bed spaces, the new beds can be added very quickly and at no significant cost.

4. People in Tennessee should have confidence that the quality of health care is continually monitored and standards are adhered to by providers.

Crestwyn and Acadia Healthcare have strong quality improvement processes; and Crestwyn is both licensed and accredited.

5. The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

The project will require some new staff but not a large number of staff.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of the publication of the letter of intent.

NOTIFICATION REQUIREMENTS

(Applies only to Nonresidential Substitution-Based Treatment Centers for Opiate Addiction)

Note that T.C.A. §68-11-1607(c)(3) states that "... Within ten (10) days of filing an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the member(s) of the House of Representatives and the Senator of the General Assembly representing the district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution based treatment center for opiate addiction has been filed with the agency by the applicant."

Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

Please provide documentation of these notifications.

See Attachment "Proof of Publication".

DEVELOPMENT SCHEDULE

T.C.A. §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

- 1. Complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.
- 2. If the response to the preceding question indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph, please state below any request for an extended schedule and document the "good cause" for such an extension.

PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1. below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

PHASE	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Initial HSDA Decision Date	0	
1. Architectural & engineering contract signed		
2. Construction documents approved by TDH		
3. Construction contract signed		
4. Building permit secured		
5. Site preparation completed		
6. Building construction commenced		
7. Construction 40% complete		
8. Construction 80% complete		
9. Construction 100% complete		
10. * Issuance of license		
11. *Initiation of service		
12. Final architectural certification of payment		
13. Final Project Report Form (HF0055)		

^{*} For projects that <u>DO NOT</u> involve construction or renovation: please complete items 11-12 only.

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

AFFIDAVIT

STATE OFTENNESSEE
COUNTY OFDAVIDSON
JOHN WELLBORN, being first duly sworn, says that he is the lawful agent of the applicant named in this application, that this project will be completed in accordance with the application to the best of the agent's knowledge, that the agent has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, et seq., and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete to the best of the agent's knowledge.
Jum & Wellow SIGNATURE/TITLE CONSULTANT
Sworn to and subscribed before me this 14th day of march, 2018 a Notary
Public in and for the County/State of <u>DAVIDSON</u>
My commission expires (Month/Day) NOTARY PUBLIC NOTARY PUBLIC (Year) STATE TENNESSEE NOTARY PUBLIC

INDEX OF ATTACHMENTS

Section A

A-4A Legal Status and Ownership Structure of Applicant

A-6A Site Control Documentation

A-6B(1)a-d Plot Plan

A-6B(2) Floor Plan

Section B

B-Need-3 Service Area Map

B-Economic Feasibility-2 Documentation of Funding/Financing Availability

B-Economic Feasibility-6A Applicant's Financial Statements

B-Orderly Development-4B Licensure and Accreditation Findings and Corrections

Other Attachments

Proof of Publication

Support Letters

A-4A Legal Status and Ownership Structure of Applicant

STATE OF TENNESSEE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES



LICENSE

THE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES GRANTS THIS FULL LICENSE IN ACCORDANCE WITH TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4 TO:

CRESTWYN HEALTH GROUP, LLC DBA CRESTWYN BEHAVIORAL HEALTH

(Name of Licensee)

TO OPERATE A FACILITY OR SERVICE IDENTIFIED AND LOCATED AS FOLLOWS FOR THE PROVISION OF MENTAL HEALTH, PERSONAL SUPPORT, OR ALCOHOL AND DRUG ABUSE SERVICES:

Crestwyn Health Group, LLC DBA Crestwyn Behavioral Health

(Name of Facility or Service as Known to the Public)

9485 Crestwyn Hills Cove, Memphis, TN 38125

(Street Address or Location, City or Town)

THE LICENSEE HAS DEMONSTRATED COMPLIANCE WITH T.C.A. TITLE 33, CHAPTER 2, PART 4 AND WITH RULES OF THE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

THIS LICENSE AUTHORIZES LIFE SAFETY OCCUPANCY CLASSIFICATIONS AND THE FOLLOWING DISTINCT CATEGORY OF FACILITY OR SERVICES TO BE PROVIDED.

	Accessible to	Approved f	or persons w	
Licerise Category	mobile, non- ambulatory individuals	hearing loss	vislon loss	Capacity
Mental Health Hospital	n/a	п/а	n/a	66
Mental Health Outpatient Facility	Y	Υ	Y	n/a
Mental Health Partial Hospitalization Facility	Y	Υ	Y	n/a
MH Intensive Day Treatment for Children & Adolescents	Υ	Y	Y	n/a

July 06, 2017	March 31, 2018	L000000020593
Effective Date	Date License Expires	License Number
	· •	

Commissioner of Mental Health and Substance Abuse Services

THIS LICENSE IS NON-TRANSFERABLE AND NON-ASSIGNABLE.
POST THIS LICENSE IN A CONSPICUOUS PLACE.

Crestwyn Health Group LLC

Memphis, TN

has been Accredited by



The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the Hospital Accreditation Program

July 1, 2016
Accreditation is oustomarily valid for up to 36 months.

Laberca Jostatekins

ID #590562

Print/Reprint Date: 07/04/2016

Mark R. Cheasin, MD, FACP, MPP, MPH

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.













July 1, 2016

Re: # 590562

CCN: Pending

Program: Psychiatric Hospital

Accreditation Expiration Date: June 30, 2019

Michael J. Stokes CEO Crestwyn Health Group LLC 9485 Crestwyn Hills Memphls, Tennessee 38125

Dear Mr. Stokes:

This letter confirms that your June 27, 2016 - June 29, 2016 unannounced initial survey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals, as well as the special Conditions for psychiatric hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on July 01, 2016, The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of July 01, 2016.

The Joint Commission is also recommending your organization for Medicare certification effective July 01, 2016. Please note that the Centers for Medicare and Medicald Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is responsible for notifying the State Survey Agency that a recommendation for Medicare certification has been made. Please provide your State agency with a copy of your accreditation report, accreditation award letter, and this Medicare recommendation letter.

This recommendation applies to the following location(s):

Crestwyn Health Group d/b/a Crestwyn Behavioral Health 9485 Crestwyn Hills, Memphis, TN, 38125

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark G. Pelletier, RN, MS

Nærk Gelle

Chief Operating Officer

Division of Accreditation and Certification Operations

CMS/Central Office/Survey & Certification Group/Division of Acute Care Services CMS/Regional Office 4/Survey and Certification Staff

www.jointcommission.org

Headquarters One Renaissance Boulevard Oakbrook Terrace, IL 60181 630 792 5000 Voice

July 1, 2016

Michael J. Stokes CBO Crostwyn Health Group LLC 9485 Crestwyn Hills Memphis, TN 38125

Dear Mr. Stokes:

Joint Commission ID #: 590562 Program: Hospital Accreditation Accreditation Activity: 60-day Evidence of Standards Compliance Accreditation Activity Completed: 07/01/2016

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning June 30, 2016 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten or lengthen the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement,

Sincerely,

Mark G.Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations



Business Services Online > Find and Update a Business Record

Business Information Search

As of March 13, 2018 we have processed all corporate filings received in our office through March 12, 2018 and all annual reports received in our office through March 12, 2018.

Click on the underlined control number of the entity in the search results list to proceed to the detail page. From the detail page you can verify the entity displayed is correct (review addresses and business details) and select from the available entity actions - file an annual report, obtain a certificate of existence, file an amendment, etc.

Search:						1-1 of i
	Search Name: Cres	stwyn Behavioral Health	Starts With ∅ Contains			
	Control #:					
Activ	e Entities Only:					Search
Control#	Entity Type	Name	Name Type	Name Status	Entity Filing Date	Entity Status
000707489	LLC	Crestwyn Behavioral Health TENNESSEE	Assumed	Active	01/25/2013	Active
						1-1 of 1

Information about individual business entities can be queried, viewed and printed using this search tool for free.

If you want to get an electronic file of all business entities in the database, the full database can be downloaded for a fee by Clicking Here.

 $\underline{\it Click\, Hero}\ \ for information on the \, Business \, Services \, Online \, Search \, logic.$

Division of Business Services 312 Rosa L. Parks Avenue, Snodgrass Tower, 6th Floor Nashville, TN 37243 615-741-2286 8:00 a.m. until 4:30 p.m. (Central) Monday - Friday Directions | State Holidays | Methods of Payment

Business Filings and Information (615) 741-2286 TNSOS.CORPINFO@tn.gov Certified Copies and Certificate of Existence (615) 741-6488 | TNSOS.CERT@tn.gov Motor Vehicle Temperary Liens (615) 741-0529 | TNSOS.MVTL@tn.gov Notary Commissions (615) 741-3699 | TNSOS ATS@tn.gov Uniform Commercial Code (UCC) (615) 741-3276 | TNSOS.UCC@fingov Workers' Compensation Exemption Registrations (615) 741-0526 | TNSOS.WCER@tn.gov Apostilles & Authentications (615) 741-0536 | TNSOS ATS@tn.gov Summons (615) 741-1799 | TNSOS.ATS@(n.gov Trademorks (615) 741-0531 | TNSOS.ATS@tn.gov Nouresident Fiduciaries (615) 741-0536 | TNSOS.ATS@tn.gov

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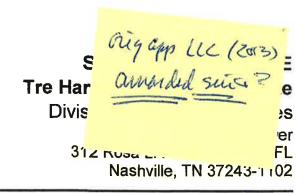
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Crestwyn Health Group, LLC STE 610 830 CRESCENT CENTRE DR FRANKLIN, TN 37067-7323

January 28, 2013

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

SOS Control #:

707489

Formation Locale:

TENNESSEE

Filing Type:

Limited Liability Company - Domestic

Date Formed:

01/25/2013

Filing Date:

01/25/2013 3:59 PM

Fiscal Year Close:

12

Status:

Active

Annual Report Due: 04/01/2014

Duration Term:

Managed By:

Perpetual

Member Managed

Image #:

7137-1468

Business County:

WILLIAMSON COUNTY

Document Receipt

Receipt #: 889033

\$300.00

Payment-Check/MO - WALLER LANSDEN DORTCH & DAVIS LLP, NASHVILLE, TN

\$300.00

Registered Agent Address:

C T CORPORATION SYSTEM

STE 2021

800 S GAY ST

KNOXVILLE, TN 37929-9710

Principal Address:

STE 610

830 CRESCENT CENTRE DR

Filing Fee:

FRANKLIN, TN 37067-7323

Congratulations on the successful filing of your Articles of Organization for Crestwyn Health Group, LLC in the State of Tennessee which is effective on the date shown above. You must also file this document in the office of the Register of Deeds in the county where the entity has its principal office if such principal office is in Tennessee. Visit the TN Department of Revenue website (apps.tn.gov/bizreg) to determine your online tax registration requirements.

You must file an Annual Report with this office on or before the Annual Report Due Date noted above and maintain a Registered Office and Registered Agent. Failure to do so will subject the business to Administrative Dissolution/Revocation.

Secretary of State

Processed By: Rita Hunter

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ARTICLES OF ORGANIZATION OF CRESTWYN HEALTH GROUP, LLC

The undersigned, acting as the organizer of a limited liability company (the "Company") under the Tennessee Revised Limited Liability Company Act, Tennessee Code Annotated, Sections 48-249-101, et seq. (the "Act"), as amended, hereby adopts the following Articles of Organization for such limited liability company:

ARTICLE I

Name

The name of the limited liability company is Crestwyn Health Group, LLC (the "Company").

ARTICLE II

Registered Office and Agent

The address of the registered office is 800 S. Gay Street, Suite 2021, Knoxville, Tennessee 37929. The name of the Company's initial registered agent is CT Corporation System.

ARTICLE III

Organizer

The name and address of the organizer of the Company is Christopher L. Howard, 830 Crescent Centre Drive, Suite 610, Franklin, Williamson County, Tennessee 37067.

ARTICLE IV

Principal Executive Office

The principal executive office of the Company is 830 Crescent Centre Drive, Suite 610, Franklin, Williamson County, Tennessee 37067.

ARTICLE V

Management

The Company shall be member-managed.

ARTICLE VI

Date of Formation

The existence of the Company is to begin upon the filing of the Articles.

Dated: January 24, 2013.

Christopher L. Howard, Organizer



STATE OF TENNESSEE Tre Hargett, Secretary of State

Division of Business Services

William R. Snodgrass Tower 312 Rosa L. Parks AVE, 6th FL Nashville, TN 37243-1102

Ann K. Rich, Paralegal WALLER LANSDEN **STE 2700** 511 UNION ST NASHVILLE, TN 37219-1791 October 1, 2012

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Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

Control #:

696885

Filing Type:

Reserved Name

10/01/2012 9:59 AM

Expiration Date:

01/31/2013

Filing Date:

Image #:

7101-0149

Status:

Active

Document Receipt

Receipt #: 829828

Filing Fee:

\$20.00

Payment-Check/MO - WALLER LANSDEN DORTCH & DAVIS LLP, NASHVILLE, TN

\$20.00

Congratulations on the successful filing of your Name Reservation for Crestwyn Health Group, LLC in the State of Tennessee on the date shown above. Please submit a copy of this acknowledgment when filing a document which utilizes this name reservation. This name expires at the close of business on the expiration date shown above.

When corresponding with this office or submitting documents for filing, please refer to the control number given above.

Secretary of State

Processed By: Tammy Morris

ACTIONS BY WRITTEN CONSENT OF THE ORGANIZER OF CRESTWYN HEALTH GROUP, LLC

Pursuant to the Tennessee Revised Limited Liability Company Act, the undersigned organizer of Crestwyn Health Group, LLC, a Tennessee limited liability company (the "Company"), hereby consents to taking action without a meeting, by written consent, and hereby takes the following actions:

The following resolutions are hereby adopted by the unanimous vote of the organizer:

Approval of Articles of Organization.

RESOLVED, that the Articles of Organization of the Company, filed with the Secretary of State of Tennessee on January 25, 2013, be, and it is hereby, accepted by the undersigned organizer as the Articles of Organization of the Company.

Acceptance of Initial Contributions.

WHEREAS, the Company has received an offer of contribution from Acadia Merger Sub, LLC, for 100 units of membership interests in the Company, representing 100% of the issued and outstanding membership interests in the Company, in exchange for the initial capital contribution of \$100.00;

NOW, THEREFORE, BE IT RESOLVED, that the aforementioned offer of contribution is fair, reasonable and adequate, and should be, and hereby is, accepted; and

RESOLVED FURTHER, that when the Company has received the initial capital contribution as specified above, the Company shall issue to the contributor the applicable units of membership interests in the Company, such units to be fully paid and non-assessable; and

RESOLVED FURTHER, that the appropriate officers and managers of the Company be, and they hereby are, authorized, empowered and directed to take all other steps necessary or advisable in order to fully effectuate such issuance.

The undersigned, being the organizer of the Company, waives all notice of the date, time, place and purpose of this special meeting of the organizer of the Company and agrees to the transaction of the business hereinabove set forth by written consent of said organizer in lieu of such meeting. This consent shall be included in the minute book of the Company.

Dated: January _____, 2013.

Christopher L. Howard, Organizer

ACTIONS BY WRITTEN CONSENT OF THE MEMBER OF CRESTWYN HEALTH GROUP, LLC

In lieu of the first meeting of the sole member of Crestwyn Health Group, LLC, a Tennessee limited liability company (the "Company"), and to complete the organization of the Company, the sole member hereby consents to taking action without a meeting, by written consent, and hereby takes the following actions:

The following resolutions are hereby adopted by the sole member:

Approval of Actions by the Organizer.

RESOLVED, that all actions taken by Christopher L. Howard as the organizer of the Company, including the making and executing of the document entitled "Actions by Written Consent of the Organizer of Crestwyn Health Group, LLC," be, and they are hereby, accepted and approved and such document shall be included in the minute book of the Company.

Approval of Articles of Organization of the Company.

RESOLVED, that the Articles of Organization of the Company, which have been presented to and reviewed by the sole member be, and it is hereby, approved and accepted by the sole member as the Articles of Organization of the Company and a copy thereof shall be included in the minute book of the Company.

3. Approval of Operating Agreement.

RESOLVED, that the proposed Operating Agreement of the Company for managing and regulating the business and affairs of the Company, which has been presented to and reviewed by the sole member be, and it is hereby, adopted and approved as the Operating Agreement of the Company and a copy thereof shall be included in the minute book of the Company.

Appointment of Officers.

RESOLVED, that the following persons be, and they hereby are, appointed to hold the office set forth opposite their names below, until their successors are duly appointed and qualified:

Joey A. Jacobs

President

Christopher L. Howard

Vice President and Secretary

Brent Turner

Vice President and Assistant Secretary

David M. Duckworth

Vice President and Treasurer

Adoption of Fiscal Year.

RESOLVED, that the Company operate on a fiscal year commencing January 1 and terminating December 31 of each year.

Resignation of Authorized Person.

RESOLVED, that the resignation of Christopher L. Howard as the organizer of the Company, be, and it is hereby, accepted and approved by the Company.

7. Further Authorization for Organization.

RESOLVED, that the appropriate officers and managers of the Company (or any of them) be, and they hereby are, authorized, empowered and directed to take all necessary or appropriate action, including the expenditure of funds, in order to fully and expeditiously complete the organization of the Company.

The undersigned member of the Company, by signing this consent, waives all notice of the date, time, place and purpose of the first meeting of the member and agrees to the transaction of the business hereinabove set forth by written consent of said member in lieu of such meeting. This consent shall be included in the minute book of the Company.

Dated: January ____, 2013.

MEMBER:

Acadia Merger Sub, LLC

By:

Name: Its:

10488368.1

January ____, 2013

TO THE MEMBER OF CRESTWYN HEALTH GROUP, LLC

The undersigned, being the organizer of Crestwyn Health Group, LLC, a Tennessee limited liability company, tenders his resignation to be effective upon acceptance.

Christopher L. Howard

Organizer

For Office Use Only

RDA 2458



Department of State

APPLICATION FOR RESERVATION OF LED

Corporate Filings 312 Rosa L. Parks Avenue 6th Floor, William R. Snodgrass Tower Nashville, TN 37243

SS-4228 (Rev. 04/08)

Note: An application for name reservation need not be filed with articles of organization.

To the Tennessee Secretary of State:

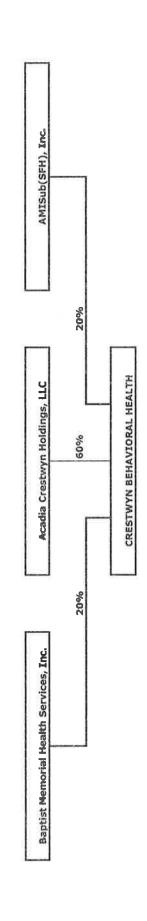
Pursuant to §48-207-102 of the Tennessee Limited Liability Company Act or §48-249-107 of the Tennessee Revised Limited Liability Company Act, the undersigned hereby applies for reservation of the following name for a period of four (4) months:

Crestwyn Health Group, LLC.

(Name to be reserved)

Ann K. Rich, Paralegal, Walle 511 Union Street, Suite 2700	Lansuell	
Nashville, TN 37219		
STAME SHEET OF THE STATE OF THE	Zip Code	
	Date: September 28 Aunk. Rich Signature	, 2012
	Ann K. Rich	
	Name (typed or printed)	
	Paralegal	

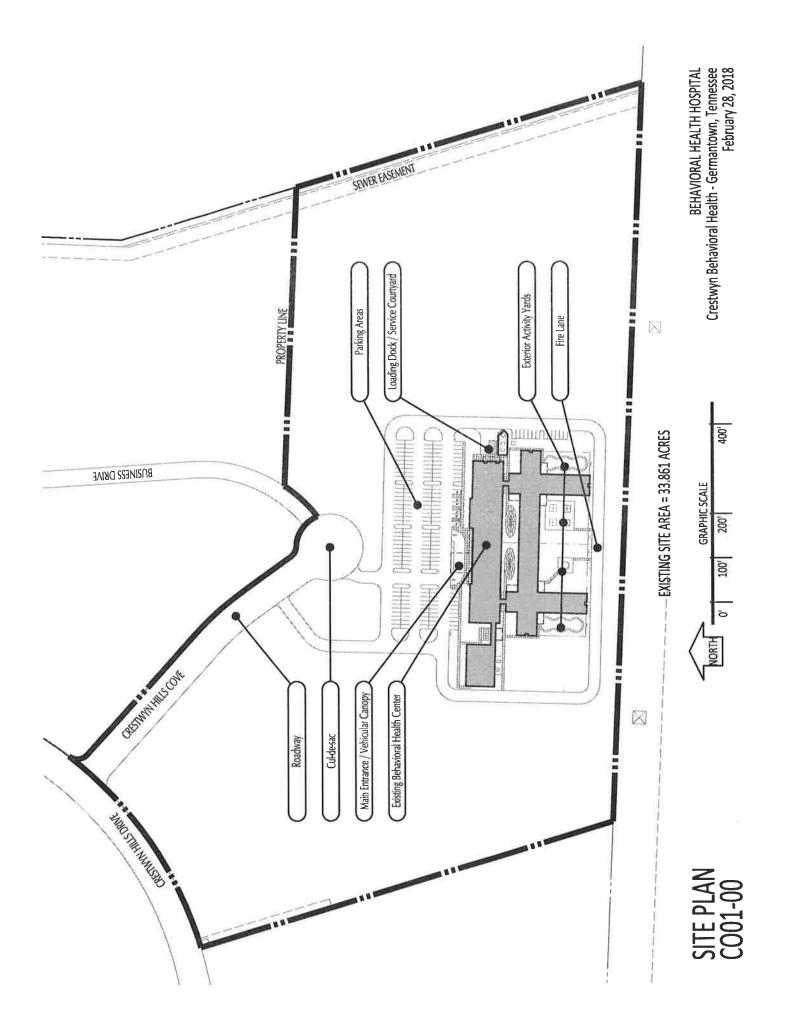
Filing Fee: \$20.00



A.6A Site Control Documentation

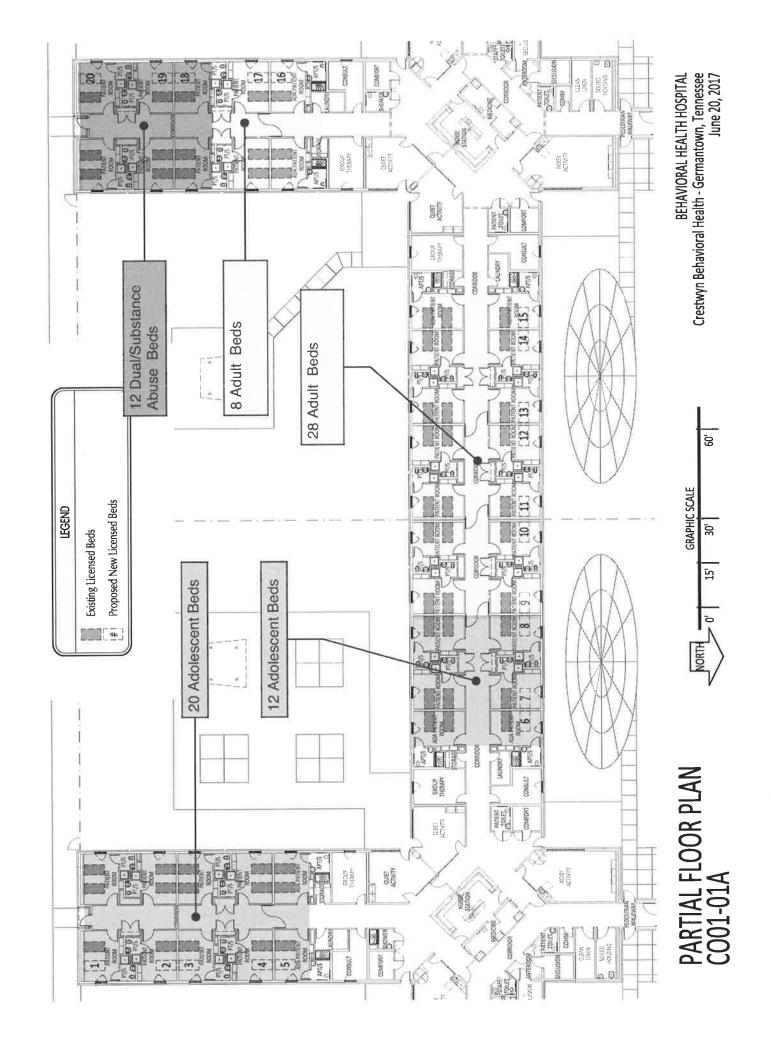
A-6B(1)a-d

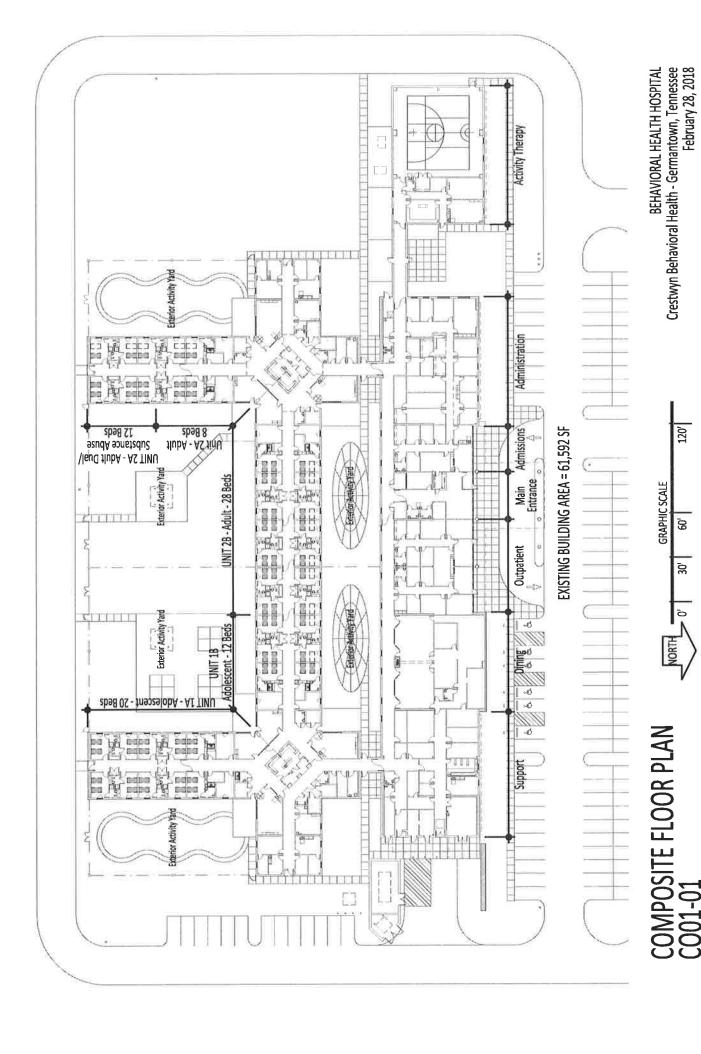
Plot Plan

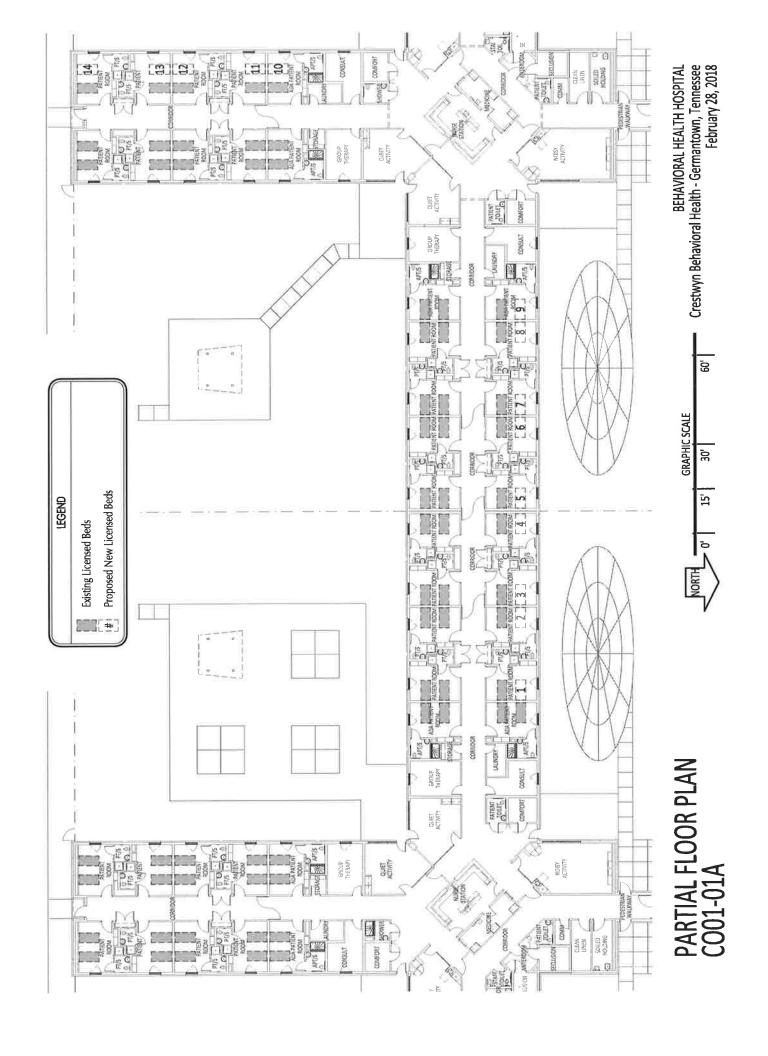


A-6B(2)

Floor Plans







B-Need-3 Service Area Map

CRESTWYN BEHAVIORAL HEALTH

Biount

BOUNT

Warren Buren

Rutherford

Roare

Monroe

McMinn

Grundy 2

Bedford Coffee

Narshall

LOWIS

Perry

Decatur

Haywood Madison

Maury

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Marion

Frankly

Lincoln

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SOUSIME?

Wayne

Tardin

Monain

Salt Bright

Fayette

Shelby

PRIMARY SERVICE AREA

B-Economic Feasibility--2

Documentation of Funding/Financing Availability



March 15, 2018

Melanie M. Hill, Executive Director Tennessee Health Facilities Commission Andrew Jackson State Office Building, Suite 850 500 Deaderick Street Nashville, Tennessee 37243

Dear Mrs. Hill:

Crestwyn Behavioral Health is applying for a Certificate of Need to add and license 14 beds in existing patient rooms. This will require a capital expenditure of no more than approximately \$91,000.

As Chief Financial Officer, I am writing to confirm that Crestwyn will fund the project in cash. The application includes our financial statements documenting that sufficient cash reserves, operating income, and lines of credit exist to accomplish that.

Sincerely,

Stephen Lewis

Chief Financial Officer

B-Economic Feasibility-6A Applicant's Financial Statements



Acadia Healthcare Crestwyn Consolidated Financial Summary Report December, 2017

	,	Period	٥						Year to Date	! 93		
Actual	Budget	Bud Var	Bud Var %	PY Var	PY Var %		Actual	Budget	Bud Var B	Bud Var %	PY Var	PY Var %
					Re	Revenues & Adjustments						
2,268,000	1,894,500	373,500	19.7%	1,093,500	93.1%	IP Gross Revenue	26,569,500	24,090,000	2,479,500	10.3%	17,415,000	190.2%
1,157,637	1,240,385	82,748	6.7%	(524,360)	(82.8%)	IP Contractual Deductions	13,746,527	15,772,413	2,025,886	12.8%	(9,480,933)	(222.3%)
11,445	37,890	26,445	89.69	14,553	56.0%	IP Rev Deducts - Admin	170,848	481,800	310,952	64.5%	1,354,382	88.8%
46,928	5,684	(41,244)	(725.6)%	(14,153)	(43.2%)	IP Rev Deducts - Charity	330,073	72,272	(257,801)	(356.7)%	(275,569)	(205,6%)
18,414	9,472	(8,942)	(94.4)%	(1,444)	(8.5%)	IP Rev Deducts - Denials	81,987	120,448	38,461	31.9%	54,738	40.0%
1,033,577	601,069	432,508	72.0%	568,096	122.0%IP	22.0% IP Net Revenue	12,240,065	7,643,067	4,596,998	60.1%	9,067,618	285.8%
166,750	212,000	(45,250)	(21.3)%	46,675	38.9%	OP Gross Revenue	1,619,450	2,372,000	(752,550)	(31.7)%	1,266,600	359.0%
97,841	153,716	55,875	36.3%	(7,536)	(8.3%)	OP Contractual Deductions	842,803	1,719,881	877,078	51.0%	(588,378)	(231.3%)
	2,120	2,120	100.0%	12,224	100.0%	OP Rev Deducts - Admin	1,016	23,720	22,704	95.7%	38,943	97.5%
	989	989	100.0%	*))(OP Rev Deducts - Charity	(204)	7,116	7,320	102.9%	204	
	1,060	1,060	100.0%			OP Rev Deducts - Denials	8,474	11,860	3,386	28.5%	(8,474)	
606'89	54,468	14,441	26.5%	51,382	282.7%OF	292.7% OP Net Revenue	767,360	609,423	157,937	25.9%	708,894	1.212.5%
1,611	41,366	(38,695)	(96.1)%	(34,621)	(95.6%)	Non Operating Revenue	480,792	494,668	(13,876)	(2.8)%	199,517	70.9%
1,104,096	696,843	407,253	58.4%	584,837	112.6%Ne	112,6%Net Revenue before Bad Debt Provision	13,488,217	8,747,158	4,741,059	54.2%	9,976,029	284.0%
47,543	19,623	(27,920)	(142.3)%	(2,060)	(4.5%)	Bad Debt Expense	833,317	249,527	(583,790)	(234.0)%	(726,017)	(678.6%)
1,056,553	677,220	379,333	56.0%	582,778	123.0%Net Revenue	Revenue	12,654,900	8,497,631	4,157,269	48.9%	9,250,012	271.7%
					o	Operating Expenses						
473,918	386,088	(87,830)	(18.5)%	(97,503)	(20.6%)	Salary Expense Less Incentive Comp	5,580,757	4,588,405	(992,352)	(17.8)%	(2,759,007)	(49.4%)
4,237	8,657	4,420	51.1%	(4,237)	1	Incentive Comp	83,643	103,884	20,041	19.3%	(83,518)	(25,697.9%)
91,068	73,439	(17,629)	(24.0)%	(18,345)	(25.2%)	Total Benefits Expense	1,095,339	910,184	(185,155)	(20.3)%	(590,334)	(116.9%)
37,674	1	(37,674)	•	(29,848)	(381.4%)	Contract Labor	170,338	á	(170,338)	*	(160,943)	(1,713.0%)
46,263	22,799	(23,464)	(102.9)%	(3,220)	(7.5%)	Purchase Svos	558,793	297,465	(261,328)	%(87.9)%	(265,295)	(90.4%)
103,534	13,464	(90,070)	(87.0)%	(65,590)	(63.4%)	Professional Fees	1,203,250	170,074	(1,033,176)	(85.9)%	(821,684)	(68.3%)
21,172	34,121	12,949	37.9%	26,978	26.0%	Supplies	438,481	433,611	(4,870)	(1.1)%	(139,995)	(46.9%)
16,747	31,139	14,392	46.2%	(5,381)	(47.3%)	Utilities	228,081	382,336	154,255	40,3%	(82,041)	(56.2%)
8,311	5,151	(3,160)	(61.4)%	(3,013)	(%6°95)	Repairs and Maintenance	104,150	61,319	(42,831)	%(8.69)	(47,603)	(842%)
3,595	2,072	(1,523)	(42.4)%	(1,791)	(49.8%)	Rent/Lease Expiless Interco Rent	44,375	24,911	(19,464)	(43.9)%	(25,223)	(96.8%)
14,117	14,117	0	1	29,316	67.5%	Insurance Expense	169,405	169,404	(1)	90	231,859	57.8%
2,542	6,584	4,042	61.4%	10,963	81.2%	Marketing Exp	104,053	80,000	(24,053)	(30.1)%	(65,369)	(169.0%)
6,083	9,083	1	1	(9,083)	,	Enterprise Growth	108,996	108,996	•8	ĸ	(108,996)	
34,020	23,483	(16,537)	(31.0)%	(711)	(2.1%)	Other Operating Expense	1,075,493	317,281	(758,212)	(70.5)%	(756,850)	(70.4%)
866,283	630,197	(236,086)	(37.5)%	(171,467)	(24.7%)Tot	(24.7%) Total Operating Expenses	10,965,353	7,647,870	(3,317,483)	(43.4)%	(5,674,998)	(107.3%)
190,271	47,023	143,248	304.6%	411,311	186.1%EBITDA	TDA	1,689,548	849,761	839,787	98.8%	3,575,014	189.6%
18.0%	%6.9%				89	EBITDA % of Net Revenue	13.4%	10.0%				
					Nov	Non-Operating Expenses						
68,719	70,211	1,492	2.1%	069	1.0%	Depreciation and Amortization	831,995	834,615	2,620	0.3%	(292, 169)	(54.1%)
83,919	000'26	13,081	13.5%	3,956	4.5%	Intercompany Interest	936,757	1,129,000	192,243	17.0%	(24,288)	(2.7%)
43,643	187,211	123,568	73.9%	113,642	72.3%Tat	72.3%Total Non Operating Expenses	1,659,757	1.963.615	303.858	15.5%	(207,460)	(14.3%)
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Acadia Healthcare Crestwyn Consolidated Financial Summary Report December, 2017

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Budget Bud Var Bud Var % PY Var PY Var %	
146,628 (120,188) 266,816 222.0%	% 524,953 (38.8%Pretax Income
	-Provision for Income Taxes
148,628 (120,188) 266,816 222,0%	222.0% 524.953 138.8%Net Income from Operations 29,791 (1
146,628 (120,188) 266,816 222.0%	222.0% 524,953 138.8%Net Income
20 188) 266 R16 222 ()	% 524.953 138.8%Not locome Attributable to Acadia

Arrhizal	Burdant	Rud Var	Bud Var %	PY Var	DY Var %
29,791	(1,113,854)	1,143,645	102.7%	3,367,554	100.9%
9	٠	*	٠	278	100.0%
29,791	(1,113,854)	1,143,645	102.7%	3,367,832	100.9%
29,791	(1,113,854)	1,143,645	102.7%	3,367,832	100.9
29.791	(1.113,854)	1,143,645	102.7%	3,367,832	100.9%

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders Acadia Healthcare Company, Inc.

We have audited Acadia Healthcare Company, Inc.'s internal control over financial reporting as of December 31, 2016, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the "COSO criteria"). Acadia Healthcare Company, Inc.'s management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

As indicated in the accompanying Management's Report on Internal Control Over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of Priory Group No. 1 Limited, Serenity Knolls, TrustPoint Hospital and Pocono Mountain Recovery Center, which are included in the December 31, 2016 consolidated financial statements of Acadia Healthcare Company, Inc. and constituted \$1.7 billion and \$275.6 million of total and net assets, respectively, as of December 31, 2016 and \$766.3 million or \$(49.4) million of revenues and net income, respectively, for the year then ended. Our audit of internal control over financial reporting of Acadia Healthcare Company, Inc. also did not include an evaluation of the internal control over financial reporting of Priory Group No. 1 Limited, Serenity Knolls, TrustPoint Hospital and Pocono Mountain Recovery Center.

In our opinion, Acadia Healthcare Company, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2016, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Acadia Healthcare Company, Inc. as of December 31, 2016 and 2015, and the related consolidated statements of income, comprehensive income, equity, and cash flows for each of the three years in the period ended December 31, 2016 and our report dated February 24, 2017 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Nashville, Tennessee February 24, 2017

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders

Acadia Healthcare Company, Inc.

We have audited the accompanying consolidated balance sheets of Acadia Healthcare Company, Inc. as of December 31, 2016 and 2015, and the related consolidated statements of income, comprehensive income, equity, and cash flows for each of the three years in the period ended December 31, 2016. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Acadia Healthcare Company, Inc. at December 31, 2016 and 2015, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2016, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Acadia Healthcare Company, Inc.'s internal control over financial reporting as of December 31, 2016, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework), and our report dated February 24, 2017 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Nashville, Tennessee February 24, 2017

Acadia Healthcare Company, Inc. Consolidated Balance Sheets

	****	Decemb	ber 31	
	(1	2016 n thousands, exc share ar	•	
ASSETS		3,1210 0,		
Current assets:				
Cash and cash equivalents	\$	57,063	\$	11,215
Accounts receivable, net of allowance for doubtful accounts of \$38,916 and \$29,332,				
respectively		263,327		216,626
Other current assets		107,537	_	66,895
Total current assets		427,927		294,736
Property and equipment:				
Land		411,331		214,138
Building and improvements		2,031,819		1,277,800
Equipment		318,020		141,543
Construction in progress		157,114		195,042
Less accumulated depreciation		(214,589)	-	(119,470)
Property and equipment, net	-	2,703,695		1,709,053
Goodwill		2,681,188		2,128,215
Intangible assets, net		83,310		59,575
Deferred tax assets – noncurrent		3,780		49,114
Derivative instruments		73,509		-
Other assets		51,317		38,515
Total assets	\$	6,024,726	\$	4,279,208
LIABILITIES AND EQUITY	-		2009	
Current liabilities:				
Current portion of long-term debt	\$	34,805	\$	45,360
Accounts payable		80,034		91,341
Accrued salaries and benefits		105,068		80,696
Other accrued liabilities		122,958	_	72,806
Total current liabilities		342,865	3.0	290,203
Long-term debt	Þ	3,253,004		2,195,384
Deferred tax liabilities – noncurrent		78,520		23,936
Other liabilities		164,859		78,602
Total liabilities	_	3,839,248		2,588,125
Redeemable noncontrolling interests		17,754		8,055
Equity:		,		
Preferred stock, \$0.01 par value; 10,000,000 shares authorized, no shares issued		-		_
Common stock, \$0.01 par value; 180,000,000 and 90,000,000 shares authorized at December 31, 2016 and 2015, respectively; 86,688,199 and 70,745,746 issued				
and outstanding as of December 31, 2016 and 2015, respectively		867		707
Additional paid-in capital		2,496,288		1,572,972
Accumulated other comprehensive loss		(549,570)		(104,647
Retained earnings		220,139		213,996
Total equity		2,167,724		1,683,028
Total liabilities and equity	\$	6,024,726	\$	4,279,208
Total Habilities and equity	-		2000	

See accompanying notes.

Acadia Healthcare Company, Inc. Consolidated Statements of Income

	Year Ended December 31			r 31,	1,	
		016		2015		2014
				ept per sha		
Revenue before provision for doubtful accounts		52,823	\$1,	829,619	\$1,	,030,784
Provision for doubtful accounts	(2	11,909)		(35,127)		(26,183)
Revenue	2,8	10,914	1,	794,492	1,	,004,601
Salaries, wages and benefits (including equity-based compensation expense of \$28,345,						
\$20,472 and \$10,058, respectively)	1,54	11,854		973,732		575,412
Professional fees		35,486		116,463		52,482
Supplies		17,425		80,663		48,422
Rents and leases		73,348		32,528		12,201
Other operating expenses		12,556		206,746		110,654
Depreciation and amortization	13	35,103		63,550		32,667
Interest expense, net	18	81,325		106,742		48,221
Debt extinguishment costs		4,253		10,818		1577
Loss on divestiture	1	78,809				
(Gain) loss on foreign currency derivatives		(523)		1,926		(15,262)
Transaction-related expenses	4	48,323		36,571		13,650
Total expenses	2,7	77,959	1,	629,739		878,447
Income from continuing operations before income taxes		32,955		164,753		126,154
Provision for income taxes		28,779		53,388		42,922
Income from continuing operations		4,176		111,365		83,232
Income (loss) from discontinued operations, net of income taxes				111		(192
Net income		4,176		111,476	_	83,040
Net loss attributable to noncontrolling interests		1,967		1,078		05,010
	\$	6,143	\$	112,554	0	83,040
Net income attributable to Acadia Healthcare Company, Inc.	2	0,143	-D	112,334	Φ_	03,040
Basic earnings attributable to Acadia Healthcare Company, Inc. stockholders:						
Income from continuing operations	\$	0.07	\$	1.65	\$	1.51
Income (loss) from discontinued operations		_	-		_	-
Net income	\$	0.07	\$	1.65	\$	1.51
Diluted earnings attributable to Acadia Healthcare Company, Inc. stockholders:	-		1			
Income from continuing operations	\$	0.07	\$	1.64	\$	1.50
Income (loss) from discontinued operations				-		-
Net income	\$	0.07	S	1.64	\$	1.50
	Ψ	0.07		1,07	4	1,50
Weighted-average shares outstanding:		05.701		CO 005		55.062
Basic		85,701		68,085		55,063
Diluted		85,972		68,391		55,327

See accompanying notes.

Acadia Healthcare Company, Inc. Consolidated Statements of Comprehensive Income

	Year Ended December 31,			r 31,
	-	2016	2015 (In thousands)	2014
Net income	\$	4,176	\$111,476	\$ 83,040
Other comprehensive loss:				
Foreign currency translation loss	(4	477,772)	(40,103)	(66,206)
Gain on derivative instruments, net of tax of \$29.1 million, \$0 and \$0, respectively		40,598	-	_
Pension liability adjustment, net of tax of \$1.3 million, \$0.9 million and \$0.6 million, respectively		(7,749)	3,826	(2,164)
Other comprehensive loss	(-	444,923)	_(36,277)	(68,370)
Comprehensive (loss) income	(-	440,747)	75,199	14,670
Comprehensive loss attributable to noncontrolling interests	-	1,967	1,078	
Comprehensive (loss) income attributable to Acadia Healthcare Company, Inc.	\$(438,780)	\$ 76,277	\$ 14,670

See accompanying notes.

Acadia Healthcare Company, Inc. Condensed Consolidating Balance Sheets December 31, 2015 (In thousands)

		arent	Su	ombined bsidiary arantors		ombined Non- arantors		olidating stments		Total usolidated unounts
Current assets:		C-11031-32			4	0.440	de		Ф	11.016
Cash and cash equivalents	\$	-	\$	1,987	\$	9,228	\$	=	\$	11,215
Accounts receivable, net		1000		187,546		29,080				216,626
Other current assets	-			57,968	-	8,927				66,895
Total current assets		- 120		247,501		47,235		-		294,736
Property and equipment, net				805,439		903,614		-		,709,053
Goodwill		-	1.	835,339		292,876		_	2	,128,215
Intangible assets, net				57,024		2,551		-		59,575
Deferred tax assets - noncurrent		3,946		40,587		4,581				49,114
Investment in subsidiaries	3,	495,067		_			11.00.1.5.1.01.1	195,067)		
Other assets		427,270		32,947	2000	2,322	(-	124,024)	-	38,515
Total assets	\$3.	926,283	\$3,	018,837	\$1,	253,179	\$(3,9	19,091)	\$4	,279,208
Current liabilities:							120			
Current portion of long-term debt	\$	45,125	\$		\$	235	\$	-	\$	45,360
Accounts payable				75,015		16,326		1000		91,341
Accrued salaries and benefits				66,249		14,447				80,696
Other accrued liabilities		26,132	-	10,886		35,788		-	-	72,806
Total current liabilities		71,257		152,150		66,796				290,203
Long-term debt	2	171,998		-		447,410	. (+	124,024)	2	,195,384
Deferred tax liabilities - noncurrent				-		23,936		-		23,936
Other liabilities		_		75,159		3,443	1		_	78,602
Total liabilities	2	243,255		227,309		541,585	(4	424,024)	2	,588,125
Redeemable noncontrolling interests			- 5	7117		8,055	777		1 (20)	8,055
Total equity	1.	683,028	2.	,791,528		703,539	(3,4	495,067)	_1	,683,028
Total liabilities and equity	\$3.	926,283	\$3.	,018,837	\$1,	253,179	\$(3,9	919,091)	\$4	,279,208

Acadia Healthcare Company, Inc. Condensed Consolidating Statement of Comprehensive Income Year Ended December 31, 2016 (In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non- Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Revenue before provision for doubtful accounts	\$	\$1,662,734	\$1,190,089	\$ —	\$2,852,823
Provision for doubtful accounts		(38,349)	(3,560)		(41,909)
Revenue		1,624,385	1,186,529	-	2,810,914
Salaries, wages and benefits	28,345	865,104	648,405	_	1,541,854
Professional fees	-	89,062	96,424	-	185,486
Supplies	_	76,246	41,179		117,425
Rents and leases	_	34,540	38,808	_	73,348
Other operating expenses		206,308	106,248		312,556
Depreciation and amortization		58,018	77,085		135,103
Interest expense, net	50,921	75,848	54,556		181,325
Debt extinguishment costs	4,253				4,253
Loss on divestiture		778	178,031	_	178,809
Gain on foreign currency derivatives	(523)		_	_	(523)
Transaction-related expenses		32,173	16,150		48,323
Total expenses	82,996	1,438,077	1,256,886		2,777,959
(Loss) income from continuing operations before income					
taxes	(82,996)	186,308	(70,357)		32,955
Equity in earnings of subsidiaries	65,560		_	(65,560)	
(Benefit from) provision for income taxes	(21,612)	68,335	(17,944)	*****	28,779
Income (loss) from continuing operations	4,176	117,973	(52,413)	(65,560)	4,176
Income from discontinued operations, net of income taxes					
Net income (loss)	4,176	117,973	(52,413)	(65,560)	4,176
Net loss attributable to noncontrolling interests			1,967	//P0 //P1 70	1,967
Net income attributable to Acadia Healthcare Company, Inc.	\$ 4,176	\$ 117,973	\$ (50,446)	\$ (65,560)	\$ 6,143
Other comprehensive income:					
Foreign currency translation gain			(477,772)	0 000	(477,772)
Gain on derivative instruments	40,598	-		-	40,598
Pension liability adjustment, net			(7,749)	-	(7,749)
Other comprehensive income	40,598		(485,521)		(444,923)
Comprehensive income (loss)	\$ 44,774	\$ 117,973	\$ (535,967)	\$ (65,560)	\$ (438,780)

Acadia Healthcare Company, Inc. Condensed Consolidating Balance Sheets December 31, 2016 (In thousands)

	_	Parent	Combii Subsidi Guaran	ary		mbined Non- arantors		lidating stments	Con	Total solidated mounts
Current assets:										
Cash and cash equivalents	\$			681	\$	41,382	\$	-	\$	57,063
Accounts receivable, net		www.	209,			54,203		-		263,327
Other current assets				724	_	45,813			_	107,537
Total current assets			286,			141,398		700		427,927
Property and equipment, net		2000 (A. 18)	940,			762,815		-		703,695
Goodwill		-	1,935,			745,928			2,	681,188
Intangible assets, net		26/25/07	56,	676		26,634		V==		83,310
Deferred tax assets - noncurrent		13,522		~~		4,606	(14,348)		3,780
Derivative instruments		73,509				-	704			73,509
Investment in subsidiaries		4,885,865				-		85,865)		
Other assets		493,294		480		7,189		89,646)		51,317
Total assets		5,466,190	\$3,259,	825	\$2,	688,570	\$(5,3	89,859)	\$6,	024,726
Current liabilities:										
Current portion of long-term debt	5	34,550	\$	= :	\$	255	\$	-	\$	34,805
Accounts payable		-		205		30,829		-		80,034
Accrued salaries and benefits		-		835		32,233		-		105,068
Other accrued liabilities	_	33,616		375	_	64,967			_	122,958
Total current liabilities		68,166		415		128,284		-		342,865
Long-term debt		3,230,300/	500	_		512,350	(4	89,646)	3,	,253,004
Deferred tax liabilities - noncurrent			40,	574		52,294	(14,348)		78,520
Other liabilities	_		101,	938		62,921			_	164,859
Total liabilities		3,298,466	288,	927		755,849	(5	03,994)	3,	839,248
Redeemable noncontrolling interests	-					17,754				17,754
Total equity	_	2,167,724	2,970,	898	1,	914,967	(4,8	85,865)	2,	167,724
Total liabilities and equity	9	55,466,190	\$3,259	825	\$2.	688,570	\$(5,3	89,859)	\$6,	024,726

B-Orderly Development-4B

TDOH and Joint Commission Findings and Corrections



Official Accreditation Report

Crestwyn Health Group LLC 9485 Crestwyn Hills Memphis, TN 38125

Organization Identification Number: 590562

Initial Unannounced Full Event: 6/27/2016 - 6/29/2016

Report Contents

Executive Summary

Survey Analysis for Evaluating Risk (SAFER™)

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right.

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in 60 days. (Please note: If your survey event resulted in a Preliminary Denial of Accreditation status, your timeframe for ESC completion will be 45 days.) The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Plan for Improvement

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Executive Summary

Program(s)
Hospital Accreditation

Survey Date(s) 06/27/2016-06/29/2016

Hospital Accreditation:

As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:

- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:

- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

All Evidence of Standards Compliance (ESC) forms, which outline corrective actions, will be due in 60 days. For those findings of a higher risk, two additional fields will be required within the ESC for the organization to provide a more detailed description of leadership involvement and preventive analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER Matrix Placement	Required Follow-Up Activity
LOW/LIMITED	60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections
MODERATE/LIMITED, LOW/PATTERN, LOW/WIDESPREAD	60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections
MODERATE/PATTERN, MODERATE/WIDESPREAD	 60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections ESC will also include two additional areas surrounding Leadership Involvement and Preventive Analysis Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full triennial survey
HIGH/LIMITED, HIGH/PATTERN. HIGH/WIDESPREAD	60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections ESC will also include two additional areas surrounding Leadership Involvement and Preventive Analysis Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full triennial survey

Note: If an Immediate Threat to Health and Safety, also known as Immediate Threat to Life (ITL), is discovered during a survey, the organization immediately receives a preliminary denial of accreditation (PDA) and, within 72 hours, must either entirely eliminate that ITL or implement emergency interventions to abate the risk to patients (with a maximum of 23 days to totally eliminate the ITL). Please see the Accreditation Process Chapter within the Comprehensive Accreditation Manual for more information.

The Joint Commission SAFER Matrix

Hospital Accreditation Program

			oopital Accidantation Fieg.	
	ITL			
isitor/Staff	High	PC.01.02.09 EP 7		
Likelihood to Harm a Patient/Visitor/Staff	Moderate	WT.05.01.01 EP 3	EC.02.04.03 EP 1 PC.01.02.13 EP 6 RC.02.04.01 EP 3	PC.01.02.13 EP 2 PC.01.03.01 EP 1
Likelihood t		LS.02.01.20 EP 26 MM.04.01.01 EP 9 PC.01.02.01 EP 23	MS.06.01.05 EP 7 PC.01.03.01 EP 5 RC.02.03.07 EP 4	
	Low			
		Limited	Pattern Scope	Widespread

Requirements for Improvement – Summary

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in 60 days. (Please note: If your survey event resulted in a Preliminary Denial of Accreditation status, your timeframe for ESC completion will be 45 days.) The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Summary of CMS Findings

CoP:

§482.24

Tag: A-0431

Deficiency: Standard

Corresponds to: HAP

Text:

§482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(2)	A-0450	HAP - RC.02.03.07/EP4	Standard

CoP:

§482.41

Tag: A-0700

Deficiency: Standard

Corresponds to: HAP

Text:

§482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(c)(2)	A-0724	HAP - EC.02.04.03/EP1	Standard
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.20/EP26	Standard

CoP:

§482.61

Tag: B103

Deficiency: Standard

Corresponds to: HAP

Text:

§482.61 Condition of Participation: Special medical record requirements for psychiatric

hospitals.

The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.

CoP Standard	Tag	Corresponds to	Deficiency
§482.61(e)	B133	HAP - RC.02.04.01/EP3	Standard
§482.61(a)(5)	B109	HAP - PC.01.02.13/EP6	Standard
§482.61(b)(7)	B117	HAP - PC.01.02.13/EP2	Standard
§482.61(c)(1)	B119	HAP - PC.01.03.01/EP1	Standard
§482.61(c)(1)(ii)	B121	HAP - PC.01.03.01/EP5	Standard

CoP:

§482.22

Tag: A-0338

Deficiency: Standard

Corresponds to: HAP

Text:

§482.22 Condition of Participation: Medical staff

The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital.

The Joint Commission Summary of CMS Findings

CoP Standard	Tag	Corresponds to	Deficiency
§482.22(a)(1)	A-0340	HAP - MS.06.01.05/EP7	Standard

Requirements for Improvement - Detail

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.02.04.03

Standard Text:

The hospital inspects, tests, and maintains medical equipment.

Element(s) of Performance:

1. For hospitals that do not use Joint Commission accreditation for deemed status purposes: Before initial use of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. (See also EC.02.04.01, EP 2)

For hospitals that use Joint Commission accreditation for deemed status purposes: Before initial use and after major repairs or upgrades of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. (See also EC.02.04.01, EP 2)

Likelihood to Cause Harm:

Moderate

Scope:

Pattern

Observation(s):

EP 1

§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

This Standard is NOT MET as evidenced by:

Observed in Document Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

During the document review and staff interview it was observed that the hospital did not perform safety, operational and functional checks before initial use for all of the hospital's medical equipment listed on the medical equipment inventory list. It was observed that the hospital started receiving their patients on May 2, 2016 and the documentation verified that the initial inspections of the medical equipment which includes but not limited to 3 AED devices were not conducted until June 2, 2016.

Chapter:

Life Safety

Program:

Hospital Accreditation

Standard:

LS.02.01.20

Standard Text:

The hospital maintains the integrity of the means of egress.

Element(s) of Performance:

26. In new buildings, no dead-end corridor is longer than 30 feet. (For full text and any exceptions, refer to NFPA 101-2000: 18.2.5.10)

Note: Existing dead-end corridors are permitted to be used if it is impractical and unfeasible to alter them. (For full text and any exceptions, refer to NFPA 101-2000: 19.2.5.10)

Likelihood to Cause Harm: Low Scope: Limited

Observation(s):

EP 26

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

During the building tour it was observed that the corridor near the dietary department and hazardous area room 1154 had a dead end corridor that was greater than 30 feet.

Chapter: Medical Staff

Program: Hospital Accreditation

Standard: MS.06.01.05

Standard Text: The decision to grant or deny a privilege(s), and/or to renew an existing privilege

(s), is an objective, evidence-based process.

Element(s) of Performance:

7. The hospital queries the National Practitioner Data Bank (NPDB) when clinical privileges are initially granted, at the time of renewal of privileges, and when a new privilege(s) is requested.

Likelihood to Cause Harm: Low Scope: Pattern

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EP 7

§482.22(a)(1) - (A-0340) - (1) The medical staff must periodically conduct appraisals of its members.

This Standard is NOT MET as evidenced by:

Observed in Credentialing and Privileging at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 2 of 3 medical staff/credentialing files reviewed, Radiologist chart's had the NPDB queried in 2014, but not before starting work for the hospital in May 2016

Chapter:

Medication Management

Program:

Hospital Accreditation

Standard:

MM.04.01.01

Standard Text:

Medication orders are clear and accurate.

Element(s) of Performance:

9. A diagnosis, condition, or indication for use exists for each medication ordered.

Note: This information can be anywhere in the medical record and need not be on the order itself. For example, it might be part of the medical history.

Likelihood to Cause Harm:

Low

Scope:

Limited

Observation(s):

EP9

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. One record had multiple medications that did not have indications. The medications were Depakote and Geodon. The MD note did not explain the use of the medications.

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.01.02.01

Standard Text: The hospital assesses and reassesses its patients.

Element(s) of Performance:

23. During patient assessments and reassessments, the hospital gathers the data and information it requires. (See also PC.01.01.01, EP 24)

Likelihood to Cause Harm: Low Scope : Limited

Observation(s):

EP 23

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. One patient who scored low fall risk was not rescreened in one week according to directions on the form. However, the policy for fall risk does not address reassessments.

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. While the CAGE assessment had been done, the actual alcohol assessment had not been done. The patient was admitted 6/21/16 and the assessment should be done within 72 hours according to hospital policy.

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. In 1 of 10 patient records reviewed, of both open and closed medical records the section of the medical history and physical exam that addressed previous surgical procedures was left blank. It is likely that the patient, an adolescent, had not had any procedures in the past, however, that should have been indicated in the medical history and physical examination.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.02.09

Standard Text: The hospital assesses the patient who may be a victim of possible abuse and

neglect.

Element(s) of Performance:

7. The hospital reports cases of possible abuse and neglect to external agencies, in accordance with law and regulation. (See also RI.01.06.03, EP 3)

Likelihood to Cause Harm: High Scope : Limited

Observation(s):

EP 7

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. In 1 of 1 patient records reviewed, closed medical record of a 17 year old adolescent who had been admitted for severe depression and melancholy in part related to her first sexual encounter which she related to care givers upon admission. The encounter had occurred, ostensibly, with a 25 year old man. There was no discussion in the medical record that the sexual molestation had been reported to the Division of Child **Protective Services.**

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.01.02.13

Standard Text:

The hospital assesses the needs of patients who receive treatment for emotional

and behavioral disorders.

Element(s) of Performance:

2. Patients who receive treatment for emotional and behavioral disorders receive an assessment that includes the following:

- Current mental, emotional, and behavloral functioning

- Maladaptive or other behaviors that create a risk to the patient or others
- Mental status examination
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Reason for admission as stated by the patient and/or others significantly involved in the patient's care
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Onset of the patient's illness and circumstances leading to admission
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Inventory of the patient's strengths and disabilities (such as psychiatric, biopsychosocial problems requiring treatment/intervention) written in a descriptive manner on which to base a treatment plan (See also PC.01.03.01, EP 1)

Likelihood to Cause Harm:

Moderate

Scope:

WideSpread

- 6. Based on the patient's age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following:
- A psychiatric evaluation
- Psychological assessments, including intellectual, projective, neuropsychological, and personality testing
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Complete neurological examination at the time of the admission physical examination, when indicated (For more information on physical examination, see PC.01.02.03, EP 4)

Likelihood to Cause Harm: Moderate Scope : Pattern

Observation(s):

EP 2

§482.61(b)(7) - (B117) - (7) Include an inventory of the patient's assets in descriptive, not interpretative, fashion. This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 9 of 10 patient records reviewed, Both open and closed medical records reviewed the inventory of assets checked in the psychiatric evaluation did not give sufficient detail to determine how they should be used in treatment of the patient. The recreation therapist did detail activity preferences including games, television programs, sports in the activities interventions of the plan. However, these don't demonstrate the personal strengths as defined in the interpretive guidelines of conditions of participation: "..although the term strength is often used interchangeably with assets, only the assets which describe personal strengths on which to base the treatment plan or which are useful in therapy represent personal strengths. Strengths are personal attributes i.e. knowledge, skills, aptitudes, personal experiences, education, talents and employment status which may be useful in developing a meaningful treatment plan..."

EP 6

\$482.61(a)(5) - (B109) - (5) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.

This Standard is NOT MET as evidenced by:

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 1 of 10 patient records reviewed, One of the 10 open and closed medical records reviewed had an incomplete neurological exam. The cranial nerve evaluation was not completed.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.03.01

Standard Text: The hospital plans the patient's care.

Element(s) of Performance:

1. The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. (See also RC.02.01.01, EP 2; PC.01.02.13, EP 2)

Likelihood to Cause Harm: Moderate Scope : WideSpread

5. The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals. Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The patient's goals include both short- and long-term goals.

Likelihood to Cause Harm: Low Scope : Pattern

Observation(s):

EP 1

§482.61(c)(1) - (B119) - (1) Each patient must have an individual comprehensive treatment plan that must be based on an inventory of the patient's strengths and disabilities.

The written plan must include—

This Standard is NOT MET as evidenced by:

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 9 of 10 patient records reviewed, Both open and closed it was evident that the treatment plan was not based on the inventory of the patient's strengths and disabilities. The selection of strengths and disabilities that is attached to the Master Treatment Plan is a check list and not further referenced in the goals established in the treatment plan. It also does not correlate with the inventory of strengths and disabilities of the checklist in the psychiatric evaluation. General statements such as "hobbies", "motivation", "talents" etc. should be followed with further detail of what each of those selections reference. Of note; the activities therapists do lists "likes" and "dislikes" in the treatment plans that include specific sports, activities, television etc.

EP 5

§482.61(c)(1)(ii) - (B121) - (ii) Short-term and long-range goals; This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 3 of 6 patient records reviewed, There were goals that were not measurable. Examples include: "David will process life stressors contributing to depression." and "Pt will have alternative coping strategies that reinforce positive outcomes." "will be compliant with detox protocol."

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.02.03.07

Standard Text: Qualified staff receive and record verbal orders.

Element(s) of Performance:

4. Verbal orders are authenticated within the time frame specified by law and regulation.

Likelihood to Cause Harm: Low Scope : Pattern

Observation(s):

FP 4

§482.24(c)(2) - (A-0450) - (2) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 2 of 7 patient records reviewed, Verbal orders had not been signed within the 48 hours which was the hospital's policy. One telephone order contained 5 different medications and was given on 5/11/16 and was signed on 5/14/16. Another medication had been given on 6/23/15 and had not been signed by 6/27/16 during the survey.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.02.04.01

Standard Text: The hospital documents the patient's discharge information.

Element(s) of Performance:

- 3. In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the following:
- The reason for hospitalization
- The procedures performed
- The care, treatment, and services provided
- The patient's condition and disposition at discharge
- Information provided to the patient and family
- Provisions for follow-up care

Note 1: A discharge summary is not required when a patient is seen for minor problems or interventions, as defined by the medical staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care.

Note 2: When a patient is transferred to a different level of care within the hospital, and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used.

Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The record of each patient discharged needs to include a discharge summary with the above information. The exceptions in Notes 1 and 2 are not applicable. All patients discharged need to have a discharge summary.

Likelihood to Cause Harm:

Moderate

Scope:

Pattern

Observation(s):

§482.61(e) - (B133) - §482.61(e) Standard: Discharge planning and discharge summary.

The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the patient's hospitalization and

This Standard is NOT MET as evidenced by:

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 3 of 3 patient records reviewed, All closed medical records that had a discharge summary and "Discharge Plan" there was a recapitulation of the patient's hospital course, however, none of the three contained a detail of the goals and specifically goal attainment.

Chapter:

Waived Testing

Program:

Hospital Accreditation

Standard:

WT.05.01.01

Standard Text:

The hospital maintains records for waived testing.

Element(s) of Performance:

3. Quantitative test result reports in the medical record for waived testing are accompanied by reference intervals (normal values) specific to the test method used and the population served. Note 1: Semiquantitative results, such as urine macroscopic and urine dipsticks, are not required to comply with this element of performance.

Note 2: If the reference intervals (normal values) are not documented on the same page as and adjacent to the waived test result, they must be located elsewhere within the permanent medical record. The result must have a notation directing the reader to the location of the reference intervals (normal values) in the medical record.

Likelihood to Cause Harm:

Moderate

Scope:

Limited

Observation(s):

EP3

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. In 1 of 1 patient records reviewed, Closed medical record of a very brittle diabetic patient it was noted that the reference ranges for the device used for point of care testing for blood glucose was not in the patient's medical record.

Plan for Improvement - Summary

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Number of PFIs: 0







Alliance Healthcare Services

Date: March 12, 2018

Melanie Hill **Executive Director** Tennessee Health Services & Development Agency Frost building, 3rd Floor 161 Rosa Park Blvd. Nashville, TN 37243

RE: Crestwyn Behavioral Health

Dear Ms. Hill:

On behalf of the staff of Alliance Healthcare Services, I want to express our strong support for the certificate of need application referenced above.

Alliance Healthcare Services is the largest provider of outpatient mental health care in Shelby County. We serve individuals and families of all ages. We accept TennCare, Medicare, Safety Net, some private insurance and have a sliding scale fee. Our services include outpatient medicine management; individual, group, and family therapy; care coordination; peer support; a continuum of housing services; and a continuum of crisis services. In addition, we provide services for many specialty grants and are adding primary care.

Alliance Healthcare Services would like to express its support in Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout the city. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community and would be a great benefit not only for Shelby County, but, surrounding communities as well.

Sincerely

Gene Lawrence, CEO

(901)369-1420 (901)567-3558

glawrence@alliance-hs.org



March 9, 2018:

Melanie Hill
Executive Director
Tennessee Health Services & Development Agency
Frost building, 3rd Floor
161 Rosa Park Blvd.
Nashville, TN 37243

RE: Crestwyn Behavioral Health

Dear Ms. Hill:

On behalf of the staff of Youth Villages Specialized Crisis Services, I want to express our strong support for the certificate of need application referenced above.

The Youth Villages Specialized Crisis Services staff provides assessment and evaluation of children and youth, up to age 18, who are experiencing a psychiatric emergency across the state of Tennessee.

Youth Villages would like to express its support in Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout the city. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community and would be a great benefit not only for Shelby County, but, surrounding communities as well.

Sincerely,

Brittany Farrar Brittany Farrar

Director - Youth Villages Specialized Crisis Services

615-250-7322

Brittany.farrar@youthvillages.org

3310 Perimeter Hill Drive, Nashville, TN 37211 office 615.250.7200 |

www.youthvillages.org



February 16, 2018

Melanie Hill, Executive Director Tennessee Health Services & Development Agency Frost building, 3rd Floor 161 Rosa Park Blvd. Nashville, TN 37243

RE: Crestwyn Behavioral Health Certificate of Need Application

Dear Ms, Hill:

On behalf of NAMI Memphis I want to express our strong support for the certificate of need application referenced above.

NAMI Memphis is a non-profit, self-help organization offering support, education and information to individuals living with mental illness as well as their family and friends. Since 1984 the mission of NAMI Memphis has been to improve the quality of life for persons with severe and persistent mental illnesses and for their families/caregivers, metal health providers, police officers, and the general public through education, support, and advocacy. NAMI provides classes and support groups to mentally ill individuals; their families, friends, and caregivers; and advocacy in areas such as housing, insurance coverage, and health services. At the state and federal levels, NAMI advocates for fair and nondiscriminatory laws, and works to eliminate the stigma surrounding mental illness and brain disorders.

NAMI Memphis would like to express its support for Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016 Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout Memphis and Shelby County. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community and would be a great benefit not only for Memphis and Shelby County but for surrounding communities as well.

Sincerely,

Debra S. Dillon, MA, RN-BC Chief Executive Officer

> 5830 Mt. Moriah - Suite 6; Memphis, TN 38115 Phone 901.725.0305 - Fax 901.725.0306



REPLY TO:

[X] COVINGTON OFFICE: 1997 Highway 51 South Covington, TN 38019 (901) 476-8967 p (901) 476-2498 f

| | RIPLEY OFFICE:

403 Commerce Street Ripley, TN 38063 (731) 635-3968 p (731) 635-4215 f

|| SOMERVILLE OFFICE:

12615 South Main Somerville, TN 38068 (901) 465-9831 p (901) 465-8070 f

DYERSBURG OFFICE: 2380 Henry Street

2380 Henry Street Dyersburg, TN 38024 (731) 287-1794 p (731) 287-1795 f

[] BROWNSVILLE OFFICE:

130 West Main Street Brownsville, TN 38012 (731) 772-9002 p (731) 772-9767 f

MILLINGTON OFFICE: 5281 Navy Road

5281 Navy Road Millington, TN 38053 (901) 873-0305 p (901) 873-0306 f February 16, 2018

Melanie Hill
Executive Director
Tennessee Health Services & Development Agency
Frost building, 3rd Floor
161 Rosa Park Blvd.
Nashville, TN 37243

RE: Crestwyn Behavioral Health

Dear Ms. Hill:

On behalf of the staff of Professional Care Services, I want to express our strong support for the certificate of need application referenced above.

Professional Care Services of West Tennessee, Inc. is an agency composed of caring and involved professionals who are trained to respond to the mental health needs of their community through assessment, intervention, treatment, rehabilitation and support. Since the beginning, the primary purpose of our agency has been to provide services for the citizens of our communities. Through our six locations, PCS offers a broad range of traditional out-patient mental health services to adults and children. Clinical services may include mental health assessment, individual and group counseling/therapy, family therapy, psychiatric evaluations and medication management. Services are provided by medical doctors, Nurse Practitioners, master's level therapists, Certified Prevention Specialists, and Care Coordinators.

I would like to express support in Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout the city. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community and would be a great benefit not only for Shelby County, but, surrounding communities as well.

Sincerely,

Jimmie Jackson

CEO

(901) 622-1630

jimmie.jackson@pcswtn.org

HELPING HANDS IN OUR COMMUNITY



February 13, 2018

Melanie Hill
Executive Director
Tennessee Health Services & Development Agency
Frost building, 3rd Floor
161 Rosa Park Blvd.
Nashville, TN 37243

RE: Crestwyn Behavioral Health

Dear Ms. Hill:

On behalf of the staff of Quinco Mental Health Center (MHC), I want to express our strong support for the certificate of need application referenced above.

Quinco MHC is a community mental health center in West Tennessee. We provide mental health and substance abuse services in seven countles (Hardeman, McNairy, Hardin, Decatur, Chester, Madison and Henderson). Quinco provides outpatient therapy, medication services, care/case management, and crisis services. Quinco Mental Health Center has placed patients at Crestwyn through both our outpatient and crisis programs.

Quinco Mental Health Center would like to express its support in Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout the city and all of West Tennessee. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community and would be a great benefit not only for Shelby County, but, surrounding communities as well.

Sincerely,

Mallin Medlin Executive Director (731)658-6113

(731)658-6165

Marlin, Medlin@quincomhc.org

li Medli



To Whom It May Concern,

First Step Recovery Centers would like to express its support in Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout the city. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community and would be a great benefit not only for Shelby County, but, surrounding communities as well.

Sincerely,

Ashley Patrick, BSW

Clinical Director

901-522-1002

901-522 1004 fax

apatrick@firststeprecovery.org



Mark White

State Representative 83rd Legislative District

217 War Memorial Building Nashville, TN 37243

(615) 741-4415 Toll Free: 1-800-449-8366 ext. 44513

Rep.Mark.White@capitol.tn.gov

House of Representatives State of Tennessee

NASHVILLE

District Office: P.O. Box 17409 Memphis, TN 38187-0409

COMMITTEES:

Fiscal Review Chairman

House Rules Committee

Education Administration & Planning Chairman - Sub Committee

Consumer and Human Resources

2-21-18
Melanie Hill
Executive Director
Tennessee Health Services & Development Agency
Frost building, 3rd Floor
161 Rosa Park Blvd.
Nashville, TN 37243

RE: Crestwyn Behavioral Health

Dear Ms. Hill:

I would like to express my support in Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout the city. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community and would be a great benefit not only for Shelby County, but, surrounding communities as well.

Sincerely,

Mark White



Germantown Police Department

1930 South Germantown Road Germantown, Tennessee 38138 Police Administration Phone—901-757-7300 Police Administration Fax—901-751-7656

February 14, 2018

Melanie Hill, Executive Director Tennessee Health Services & Development Agency Frost Building, 3rd Floor 161 Rosa Park Boulevard Nashville, TN 37243

RE: Crestwyn Behavioral Health

Dear Ms. Hill:

On behalf of the Germantown Police Department, I would like to express our strong support for the Certificate of Need application for Crestwyn Behavioral Health in Germantown, Tennessee.

The Germantown Police Department is a professional, progressive law enforcement organization committed to serving Germantown residents and visitors. With 99 officers and 21 public safety dispatchers, the Department is supported by civilian administrative staff and benefits from outstanding community support and civic involvement.

Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of mental health and substance abuse programs throughout the City of Germantown. Its close proximity to our Department has allowed us to make frequent use of their facility and services for our citizens. Having additional beds at Crestwyn would be an invaluable resource for not only the City of Germantown, but the surrounding municipalities as well.

Sincerely,

Richard L. Hall Chief of Police

Germantown Police Department

Date: 02/26/2018

Melanie Hill
Executive Director
Tennessee Health Services & Development Agency
Frost building, 3rd Floor
161 Rosa Park Blvd.
Nashville, TN 37243

Re: Crestwyn Behavioral Health Certificate of Need

Dear Ms. Hill:

On behalf of the staff of Bellevue Baptist Church Counseling Ministry, I want to express our strong support for the certificate of need application referenced above.

Bellevue Baptist Church provides "free" Biblical Counseling to both Bellevue members and non-Bellevue members. Thus; we make many referrals for Psychiatric in-patient care and I.O.P. services.

Bellevue Baptist Church would like to express its support in Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout the city. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community and would be a great benefit not only for Shelby County, but, surrounding communities as well.

Sincerely,

Name: Dr. Mark Bowman

Title: Pastor of Biblical Counseling at Bellevue Baptist Church

Phone Number: 901-347-5830

Fax: 901-347-5846

Email: markbowman@bellevue.org



February 21, 2018

To Whom It May Concern:

As the Chief Executive Officer of Revelation of Hope Counseling Services, I would like to express support of Crestwyn Behavioral Health's request for expansion of additional bed space at its facility. Since opening its door in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout West Tennessee. I have received tremendous positive feedback from individuals who have received services at Crestwyn and I am continually making referrals to Crestwyn for treatment. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community throughout West Tennessee.

Sincerely,

Urun D. Bonds, TI.
Alvin Bonds II, NCC, ACS, RPT-S, LMFT, LPC/MHSP

National Certified Counselor
Approved Clinical Supervisor
Registered Play Therapist – Supervisor
Licensed Marital & Family Therapist
Licensed Professional Counselor/Mental Health Service Provider



March 6, 2018

Melanie Hill **Executive Director** Tennessee Health Services & Development Agency Frost building, 3rd Floor 161 Rosa Park Blvd. Nashville, TN 37243

RE: Crestwyn Behavioral Health

Dear Ms. Hill:

On behalf of the staff of Delta Medical Center, I want to express our strong support for the certificate of need application referenced above. Delta Medical Center offers inpatient and outpatient hospital care in the greater Memphis, Tennessee area. We dedicate ourselves to being a center for excellence in providing behavioral health medicine, acute medical care, and a 7am-

7pm emergency department.

Delta Medical Center would like to express its support in Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout the city. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community and would be a great benefit not only for Shelby County, but, surrounding communities as well.

Sincerely

Phil Willcoxon

Chief Executive Officer

(O) 901-369-8501

(F) 901-369-8503

phil.willcoxon@deltamedcenter.com



State of Tennessee Health Services and Development Agency

Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243 www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

April 1, 2018

John Wellborn, Consultant Development Support Group 4219 Hillsboro Road, Suite 210 Nashville, TN 37215

RE: Certificate of Need Application – Crestwyn Behavioral Health - CN1803-018

The addition of 14 psychiatric beds to the existing 66-bed mental health hospital resulting in 80 total beds. The increase in licensed bed capacity will be achieved by adding new beds and converting existing ones as follows: the addition of 3 adult beds, increasing the total from 33 to 36; the addition of 16 child/adolescent beds, increasing the total from 16 to 32; and the conversion of dual diagnosis beds, reducing the total from 17 to 12, a reduction of 5 beds. Crestwyn Behavioral Health is located at 9485 Crestwyn Hills Cove, Memphis (Shelby County), TN. The applicant is owned by Crestwyn Health Group, LLC d/b/a Crestwyn Behavioral Health. The estimated project cost is \$91,000.

Dear Mr. Wellborn:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Laura Young at the Tennessee Department of Mental Health and Substance Abuse Services for Certificate of Need review by the Division of Planning, Research, & Forensics. You may be contacted by Ms. Young or someone from her office for additional clarification while the application is under review by the Department. Ms. Young's contact information is Laura.Young@tn.gov or 615-741-7694.

In accordance with Tennessee Code Annotated, §68-11-1607, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project began on April 1, 2018. The first 60 days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the 60-day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review. You will receive a copy of their findings. The Health Services and Development Agency will review your application on June 27, 2018.



State of Tennessee Health Services and Development Agency

Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243 **www.tn.gov/hsda** Phone: 615-741-2364 Fax: 615-741-9884

Mr. Wellborn Page 2

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

- (7) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.
- (8) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff is not prohibited.

Should you have questions or require additional information, please contact me.

Molanie M. Will/W-

cc:

Melanie M. Hill Executive Director

Laura Young, DNP APN, FPMHNP-BC



State of Tennessee Health Services and Development Agency

Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243 **www.tn.gov/hsda** Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO:

Laura Young, Chief Nursing Officer

Division of Hospital Services

TN Department of Mental Health and Substance Abuse Services

Division of Planning, Research & Forensics

Andrew Jackson Building, 6th Floor

500 Deaderick Street

Nashville, Tennessee 37243

FROM:

Melanie M. Hill MM H/MF

Executive Director

DATE:

April 1, 2018

RE:

Certificate of Need Application

Crestwyn Behavioral Health - CN1803-018

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on April 1, 2018 and end on June 1, 2018.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc:

John Wellborn

		×
	*	

LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Commercial Appeal, which is a newspaper of general circulation in Shelby County, Tennessee, on or before March 10, 2018, for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Crestwyn Behavioral Health (a behavioral health hospital), owned and managed by Crestwyn Health Group, LLC (a limited liability company), intends to file an application for a Certificate of Need to add fourteen (14) licensed beds to its facility at 9485 Crestwyn Hills Cove, Memphis, TN 38125, at a capital cost estimated at \$100,000.

The facility is licensed for 66 Mental Health Hospital beds by the Department of Mental Health and Substance Abuse Services. These consist of 33 adult psychiatric beds, 16 child/adolescent psychiatric beds, and 17 adult dual diagnosis/substance abuse beds.

This project proposes to increase total licensed beds to 80 beds. The adult units will be increased to 36 beds (increase of 3). The child/adolescent units will be increased to 32 beds (increase of 16). The dual diagnosis/substance abuse beds will be reduced from 17 beds to 12 beds (decrease of 5). All bed increases will be in existing semi-private size patient rooms that are currently used as single rooms. The project requires no construction. The project does not contain major medical equipment or initiate or discontinue any health service.

The anticipated date of filing the application is on or before March 15, 2018. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.

(Signature)

(Date)

jwdsg@comcast.net (E-mail Address)

Supplemental #1 (Copy)

Crestwyn Behavioral Health

CN1803-018

March 26, 2018

Phillip M. Earhart, HSD Examiner Tennessee Health Services and Development Agency Andrew Jackson Building, 9th Floor 502 Deaderick Street Nashville, TN 37243

RE:

CON Application CN1803-018 Crestwyn Behavioral Health

Dear Mr. Earhart:

This letter responds to your recent request for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

- 1. Section A, Executive Summary, Item 8 (Staffing), Page 4
 - a. It is noted the project will require approximately 2 nurses, 2 mental health techs, and a therapist. However, the staffing table on page 62 shows additional 3.80 techs, 1.40 nurses, and .76 recreational therapist as a result of the proposed project. Please clarify.

The applicant is amending the staffing information on page 4 and in Table Need-12 on page 62 of the application. Attached after this page are the revised pages 4R and 62R.

As reflected in the amended pages, the project will require 8.80 FTE's of additional staff. Of these, there will be 8.13 FTE's of direct patient care positions, consisting of 4.20 FTE's of mental health technicians, 2.53 FTEs of nurses, and 1.40 FTEs of Master's prepared clinicians. The original staffing chart listing a "recreational therapist" classification was inaccurate.

b. In addition, please clarify why the applicant is not hiring additional master's level or licensed therapist to provide individual and/or group therapy to the additional 14 patients if approved.

As indicated in response 1a above, additional Master's level staff is projected.

Ta	ble A-3A(3): Service Area (W	est TN and MS/AR)
	Primary Service AreaSh	elby County
Secondary Se	ervice Area Counties in Tennes	see, Arkansas, Mississippi (25)
Benton	Fayette	Lauderdale
Benton MS	Gibson	Lawrence AR
Carroll	Hardeman	Madison
Chester	Hardin	Marshall MS
Crittenden AR	Haywood	McNairy
Crockett	Henderson	Obion
Decatur	Henry	Tipton
Desoto MS	Fayette	
Dyer	Lake	

• Based on last year's patient origin at Crestwyn there will also be referrals from counties and States beyond these areas, comprising approximately 13% of admissions.

(4) Existing similar service providers

- In the primary service area (PSA) there are 14 licensed providers offering acute inpatient behavioral care. They consist of dedicated behavioral health hospitals and behavioral health units of general hospitals. Of those providers, 7 are in Shelby County; 6 are in other West Tennessee counties; and 1 is in nearby Mississippi.
- The providers include State mental health hospitals in West Tennessee, privately owned hospitals, and distinct-part behavioral units of general hospitals. A full list of all the area's providers, bed complements, and addresses is provided in Section B.Need.3 of the application.

(5) Project cost

• The project cost consists of the CON process cost and furniture for existing patient rooms. This minimal project cost estimated at \$91,000.

(6) Funding

Crestwyn Behavioral Health, the applicant, will fund the small capital costs of the project.

(7) Financial feasibility, including when the proposal will realize a positive financial margin; and

- This is an existing hospital that operates with a positive margin. The project cost is minimal. The project when implemented will not reduce the hospital's already positive operating margin.
- The hospital has available funds to implement the project.

(8) Staffing

• The project will require the addition of 8.80 FTEs of employed and contract staff, including 8.13 clinical FTE's consisting of 4.2 mental health techs, 2.53 RN's, and 1.4 Master's Level Clinicians.

	Need-12: Cres	Table Need-12: Crestwyn Behavioral Health	ral Health	
Projected Additional Staff I	Required for 1	4-Bed Expans	t Required for 14-Bed Expansion (Revised on Supplemental)	pplemental)
			Average Annual	
	Existing FTEs	Existing FTEs Projected FTEs	Salary (Contractual	Areawide / Statewide
Position Classification	(NA)	(Yr 1)	Rate)	Average Salary
A. Direct Patient Care Positions				
Mental Health Tech (MHT)	37.80	42.00	\$29,120	\$20,170
Nurse (RN)	13.70	16.23	\$70,720	\$58,410
Master's Level Clinician	5.24	6.64	\$50,000	\$40,110
Total Direct Patient Care Positions	56.74	64.87		
B. Non-Patient Care Positions				
U/M Coordinator	1.60	2.00	\$65,000	not available
Total Non-Patient Care Positions	1.60	2.00		
Total Employees (A + B)	58.34	66.87		
C. Contractual Staff	2 33	2.60		larc 1:42
Source: Crestwyn management.				7, m

2. Section A, Project Details, Item 4.B (Type of Ownership), Page 8

a. It is noted on page 8 the applicant is 40% owned by Acadia Healthcare, Inc. However, the organizational chart in the attachments indicates Acadia owns 60%. Please clarify.

This was a typographical error. Acadia owns 60%. Attached following this page is a corrected page 8R.

b. Does Acadia own other health care institutions in Tennessee? If yes, please provide the name, current address, current status of Licensure/certification, and percentage of ownership for each health care institution identified.

Acadia owns all or part of three Tennessee hospitals and is developing a fourth in partnership with Erlanger Health Systems in Chattanooga.

		Status; Licensure	Percentage of
Name	Address	and Certification	Ownership
		Operational; licensed	
		and certified for	
		Medicare and	
	4	Medicaid; Joint	Acadia 60%
Crestwyn Behavioral	9485 Crestwyn Cove,	Commission	Baptist 20%
Health	Memphis, TN 38125	accredited	St. Francis 20%
	-	Operational; licensed	
		and certified for	
		Medicare and	
		Medicaid; Joint	
Delta Medical	3000 Getwell Road,	Commission	
Center	Memphis TN 38118	accredited	Acadia 100%
		Operational; licensed	
		and certified for	
		Medicare and	
		Medicaid; Joint	
	1009 North	Commission	
	Thompson Lane,	accredited; Adding 36	
	Murfreesboro, TN	beds under CN 1502-	
Trustpoint Hospital	37129	006.	Acadia 100%
	Corner of North		
	Holtzclaw and Citico		
Erlanger Behavioral	Avenues,	CN1603-012	Acadia%
Health	Chattanooga, TN	Under Development	Erlanger %

Supplemental #1

March 27, 2018

11:42 am

An organization chart is included in Attachment Section A-4A. The applicant is a joint ventured, limited liability company. It is 60% owned by Acadia Healthcare, Inc. (a publicly traded national behavioral healthcare company), and by two Shelby County hospital providers, Baptist Memorial Hospital, Inc. (20%) and Amisub (SFH), Inc. (20%). The latter is a legal entity representing St. Francis Hospital, wholly owned by Tenet Healthcare, a multinational healthcare system headquartered in Dallas, Texas.

March 27, 2018 11:42 am

Page Three March 26, 2018

3. Section A, Project Details, Item 6A. (Legal Interest in the site), Page 9

Please provide a copy of the deed.

A copy of the deed is attached after this page.

4. Section A, Project Details, Item 9 (Medicaid/TennCare Medicare Participation) Page 13

It is noted the applicant does not have a TennCare Select contract. Please indicate if the applicant plans to contract with TennCare Select sometime in the future.

The applicant is contracted to TennCare Select through its contract with Blue Cross, which manages Select. Attached is a revise page 13R with the Select Box checked.

5. Section A. Applicant Profile, Item I, 6B (2) Floor Plan, Page 10

The floor plan is noted. However, please clarify how adults and children/adolescents will be segregated if this proposed project is approved.

The adult and child/adolescent patients occupy separate bed units. There are four program units now and there will be four when the project is implemented. They are separated by secured, steel double doors with privacy windows, and each unit is separately staffed and managed. In addition, children do not room with adolescents, the exception being a 10-12 year old patient and an adolescent no more than two years older--and then only with the approval of family and medical staff.

- 6. Section A., Bed Complement Data, Item 10.C, Page 14
 - a. It is noted the applicant has improvised the HSDA application to categorize the adult and geriatric together. Please revise the chart separating the two categories and submit a replacement page 14.

March 27, 2018 11:42 am

7. Type of Institution (Check as appropriate—more than 1 may apply)

A. Hospital (Specify):		H. Nursing Home	
B. Ambulatory Surgical Treatment		I. Outpatient Diagnostic Center	
Center (ASTC) Multi-Specialty			
C. ASTC, Single Specialty		J. Rehabilitation Facility	
D. Home Health Agency		K. Residential Hospice	
E. Hospice		L. Non-Residential Substitution-	
<u> </u>		Based Treatment Center for	
		Opiate Addiction	
F. Mental Health Hospital	X	M. Other (Specify):	
G. Intellectual Disability			
Institutional Habilitation Facility			
ICFF/IID			

8. Purpose of Review (Check as appropriate—more than 1 may apply)

A. New Institution	F. Change in Bed Complement Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation	x
B. Modifying an ASTC with limitation still required per CON C. Addition of MRI Unit D. Pediatric MRI	G. Satellite Emergency Department H. Change of Location I. Other (Specify):	
E. Initiation of Health Care Service as defined in TCA Sec 68-11-1607(4) (Specify)		

9. Medicaid/TennCare, Medicare Participation

MCO Contracts (Check all that apply:
x Amerigroup x United Healthcare Community Plan x BlueCare
x TennCare Select
Medicare Provider Number: 44-4025
Medicaid Provider Number: Q023745
Certification Type: Mental Health Hospital
If a new facility, will certification be sought for Medicare or for Medicaid/TennCare?
Medicare Yes No N/A x
Medicaid/TennCare Yes No N/A x

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As evidenced by the instrument number shown below, this document has been recorded as a permanent record in the archives of the Office of the Shelby County Register.



Supplemental #1 March 27, 2018 11:42 am

SPECIAL WARRANTY DEED

THIS INDENTURE is made and entered into as of the 31 day of March, 2015, by and between Baptist Memorial Health Services, Inc., a Tennessee non-profit corporation, party of the first part, and Crestwyn Health Group, LLC, a Tennessee limited liability company, party of the second part.

WITNESSETH:

That for and in consideration of Ten Dollars (\$10.00), cash in hand paid, and other good and valuable considerations, the receipt of all of which is hereby acknowledged, the party of the first part has bargained and sold and does hereby bargain, sell, convey, and confirm unto the party of the second part that certain real estate situated and being in the City of Germantown, County of Shelby, State of Tennessee, which is more particularly described on Exhibit "A" attached hereto and made a part of hereof for all purposes (the "Property").

The Property and this conveyance are subject to the matters and exceptions set forth on Exhibit "B" attached hereto and made a part hereof for all purposes (the "Permitted Exceptions").

TO HAVE AND TO HOLD the Property together with all the appurtenances and hereditaments thereunto belonging or in any wise appertaining unto the said party of the second part, its heirs, or successors and assigns in fee simple forever.

The said party of the first part conveys the Property, including any after acquired title of party of the first part, which is unencumbered, except for the Permitted Exceptions set forth on Exhibit "B" attached hereto, and that the title and quiet possession thereto it will warrant and forever defend against the lawful claims of all persons claiming the same by, through or under it, but not further or otherwise.

The word "party" as used herein shall mean "parties" if more than one more person or entity be referred to, and pronouns used herein shall be construed according to their proper gender and number according to the context of this instrument.

[SIGNATURE(S) ON FOLLOWING PAGE(S)]

Supplemental #1

March 27, 2018 11:42 am

SIGNATURE PAGE TO SPECIAL WARRANTY DEED

IN WITNESS WHEREOF, party of the first part has caused this instrument to be executed by and through its duly authorized officer the day and year first above written.

BAPTIST MEMORIAL HEALTH SERVICES, INC. a Tennessee non-profit corporation

By: Donald Round

Name: Donald R. Paunds
Title: Vice President

STATE OF TENNESSEE COUNTY OF SHELBY

Before me, a notary public of the state and county aforesaid, personally appeared Donald R. Pounds , with whom I am personally acquainted (or proved to me on the basis, of satisfactory evidence), and who, upon oath, acknowledged himself to be the Viet President of Baptist Memorial Health Services, Inc., a Tennessee non-profit corporation, the within named bargainor, and that he as such Viet President, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by himself as Vice President.

WITNESS my hand and seal, at office this 31 day of March, 2015.

Notary Public

My Commission Expires:

STATE
OF
TENNESSEE
NOTARY
PUBLIC
MY OF SKE

Supplemental #1 March 27, 2018 11:42 am

AFFIDAVIT OF VALUE

I, or we, hereby swear or affirm that, to the best of affiant's knowledge, information and belief, the actual consideration for this transfer or value of the property transferred, whichever is greater, is \$3,000,000.00, which amount is equal to or greater than the amount which the property transferred would command at a fair and voluntary sale.

SUBSCRIBED and sworn to me this

day of Manual, 2015.

My Commission Expires:

Property Owner:

Crestwyn Health Group, LLC

830 Crescent Centre Dr. Suite 610

Franklin, TN 37067 Ath: General Compel

Property Address:

Vacant Land

Shelby County, Tennessee

Parcel No.:

G02-43-00379C

Mail Tax Bills To:

Crestwyn Health Group, LLC

830 Crescent Centre Dr. Swife 610

Frankin, TN 37067

Attn: General Counses

Prepared by and return to:

M. Anderson Cobb, Jr.

Harris Shelton Hanover Walsh, PLLC 999 S. Shady Grove Rd., Suite 300

Memphis, TN 38120

Supplemental #1 March 27, 2018 11:42 am

EXHIBIT A

LEGAL DESCRIPTION

BEING A DESCRIPTION OF PART OF THE BAPTIST MEMORIAL HEALTH SERVICES, INC. PROPERTY AS RECORDED IN INSTRUMENT 13083488 AT THE SHELBY COUNTY REGISTER'S OFFICE, LOCATED IN GERMANTOWN, SHELBY COUNTY, TENNESSEE AND BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS:

COMMENCING AT THE INTERSECTION OF THE EAST RIGHT-OF-WAY LINE OF CRESTWYN HILLS DRIVE (68.00 FOOT WIDE PUBLIC RIGHT-OF-WAY) WITH THE SOUTH RIGHT-OF-WAY LINE OF WINCHESTER ROAD (134.00 FOOT WIDE PUBLIC RIGHT-OF-WAY); THENCE \$03°36'32"W ALONG THE EAST RIGHT-OF-WAY LINE OF SAID CRESTWYN HILLS DRIVE A DISTANCE OF 762.68 FEET TO A POINT OF CURVATURE: THENCE CONTINUING ALONG THE EAST RIGHT-OF-WAY LINE OF SAID CRESTWYN HILLS DRIVE FOLLOWING A CURVE TO THE LEFT HAVING A RADIUS OF 859.00 FEET. AN ARC LENGTH OF 504.32 FEET (CHORD S20°25'41"W - 497.11 FEET) TO THE POINT OF BEGINNING: THENCE ALONG A CURVE TO THE LEFT HAVING A RADIUS OF 30.00 FEET, AN ARC LENGTH OF 44.96 FEET (CHORD S05°41'19"E - 40.87 FEET) TO THE POINT OF TANGENCY, SAID POINT LIES ON THE PROPOSED NORTH RIGHT-OF-WAY LINE OF A 68.00 FOOT WIDE ROADWAY; THENCE \$48°37'28°E ALONG THE NORTH LINE OF SAID PROPOSED ROADWAY A DISTANCE OF 361.03 FEET TO A POINT OF CURVATURE: THENCE CONTINUING ALONG THE NORTH LINE OF SAID PROPOSED ROADWAY FOLLOWING A CURVE TO THE RIGHT HAVING A RADIUS OF 634.00 FEET, AN ARC LENGTH OF 130.20 FEET (CHORD \$42°44'28"E - 129,97 FEET) TO THE POINT OF TANGENCY: THENCE \$36°51'28"E AND CONTINUING ALONG THE NORTH LINE OF \$AID PROPOSED ROADWAY A DISTANCE OF 144.90 FEET TO A POINT OF CURVATURE: THENCE ALONG A CURVE TO THE LEFT HAVING A RADIUS OF 30,00 FEET, AN ARC LENGTH OF 27.46 FEET (CHORD \$63°04'49"E - 26.51 FEET) TO A POINT OF REVERSE CURVATURE: THENCE ALONG A CURVE TO THE RIGHT HAVING A RADIUS OF 75.00 FEET, AN ARC LENGTH OF 87.26 FEET (CHORD \$55°58'15"E - 82.42 FEET) TO A POINT ON A CURVE: THENCE LEAVING SAID PROPOSED ROADWAY AND FOLLOWING A CURVE TO THE LEFT HAVING A RADIUS OF 318.50 FEET, AN ARC LENGTH OF 100.15 FEET (CHORD N42°51'56"E - 99.74 FEET) TO A POINT; THENCE S88°22'52"E A DISTANCE OF 670.26 FEET TO A POINT ON THE EAST LINE OF SAID PHASE 9 (PLAT BOOK 177. PAGE 13); THENCE S17°24'19"E ALONG THE EAST LINE OF SAID PHASE 9 A DISTANCE OF 810.57 FEET TO THE SOUTHEAST CORNER OF SAID PHASE 9; THENCE N88°22'52"W ALONG THE SOUTH LINE OF SAID PHASE 9 AND ALONG THE NORTH LINE OF A 100 FOOT WIDE ELECTRIC TRANSMISSION LINE EASEMENT A DISTANCE OF 1657.37 FEET TO THE SOUTHWEST CORNER OF SAID PHASE 9; THENCE N17°30'46"W ALONG THE WEST LINE OF SAID PHASE 9 A DISTANCE OF 966.85 FEET TO THE WESTERN MOST NORTHWEST CORNER OF THE SAID PHASE 9 PROPERTY (PLAT BOOK 177, PAGE 13): THENCE ALONG THE SOUTHEAST RIGHT-OF-WAY LINE OF CRESTWYN HILLS DRIVE FOLLOWING A CURVE TO THE LEFT HAVING A RADIUS OF 859.00 FEET, AN ARC LENGTH OF 528.33 FEET (CHORD N54°52'02"E - 520.04 FEET) TO THE POINT OF BEGINNING AND CONTAINING 1,474,998 SQUARE FEET OR 33.861 ACRES.

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EXHIBIT "B"

PERMITTED EXCEPTIONS

- 1. City of Germantown and Shelby County taxes for the year 2015, liens, but not now due or payable.
- 2. Any tax or assessment not posted on the records of the taxing authority(ies) of which the land described in Schedule A hereof is subject, including but not limited to: Supplemental, Revised and/or Corrected Assessments pursuant to T.C.A. Section 67-5-603 et seq.; Back Assessments pursuant to T.C.A. Section 67-1-1001 et seq.; or taxes based on a change in the classification of the insured property (Roll Back Taxes) pursuant to T.C.A. Section 67-5-1001, et seq.
- 3. Subdivision restrictions, building lines and easements of record in the following plats recorded in the Shelby County Register's Office: (i) Plat Book 129, Page 43, and re-recorded in Plat Book 145, Page 60, as amended in Plat Book 160, Page 20 and re-recorded in Plat Book 166, Page 60, (ii) Plat Book 234, Page 42, (iii) Plat Book 252, Page 1, (iv) Plat Book 171, Page 9, and (v) Plat Book 177, Page 13.
- 4. A 15 foot by 23 foot drainage easement and a 15 foot by 20 foot drainage easement of record in Plat Book 171, Page 9 in the aforesaid Register's Office and as shown on survey of Michael Frye, Tennessee RLS No. 807, of The Reaves Firm, dated January 29, 2015 (the "Survey").
- 5. A 20 foot by 305 foot drainage easement and a 30 foot sewer easement of record in Plat Book 177, Page 14, in the aforesaid Register's Office and as shown on the Survey.
- 6. Declaration of Covenants, Conditions, and Restrictions of Germantown Business Park of record at Instrument No. 04079615 in the said Register's Office.
- Application for Greenbelt Assessment of record at Instrument No. 09082324 in the said Register's Office.

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Crestwyn does not assign beds separately to geriatric adults and adults under the age of 65. They are treated in separate program groups as appropriate, but are not segregated by bed unit. A revised page 14R is submitted in response to question 6b below, but the applicant respectfully declines to show a separation that does not exist operationally.

b. On line 11, the applicant added a dual diagnosis category to the adult chemical dependency category. If a patient has a primary diagnosis of mental illness, those beds would be categorized as psychiatric. Please only include adult chemical dependency beds in line 11. Please revise and include changes in replacement page 14.

Attached after this page is a replacement page 14R, with the "dual diagnosis" words removed from line 11. Patients with substance abuse diagnoses are assigned to those beds.

c. Please provide a brief description of CN1606-024A and CN1603-012A.

CN1603-012: Granted to Erlanger Behavioral Health, a joint venture of Acadia and the Erlanger Health Sytem. Establishment of a new 88-bed inpatient psychiatric hospital in Hamilton County, to include inpatient, outpatient, and substance abuse services. Twelve of the approved beds would be transfers of geropsychiatric beds from Erlanger North.

CN1606-024: Granted to Trustpoint Hospital, LLC to add 88 hospitals beds to its psychiatric and rehabilitation bed complements in Rutherford County. The approved additional beds are 14 Children's psychiatric beds, 14 adolescent psychiatric beds, 52 adult psychiatric beds, and 8 physical rehabilitation beds.

10. Bed Complement Data

A. Please indicate current and proposed distribution and certification of facility beds.)

	Beds Currently	Beds Staffed	Beds	*Beds	**Beds	TOTAL Beds at Completion
1. Medical	Licensed	Statted	Proposed	Approved	Exempt	Completion
2. Surgical						
3. ICU/CCU						
4. Obstetrical						
5. NICU6. Pediatric						
7. Adult & Geriatric	22	22	+3			36
Psychiatric	33	33	+3			30
8. Geriatric Psychiatric						
9. Child/Adolescent	1.6	1.0	116			22
Psychiatric 10 Psychiatric	16	16	+16			32
10. Rehabilitation						
11. Adult Chemical	1.7	1.7	_			1.0
Dependency	17	17	-5			12
12. Child/Adolescent						
Chemical Dependency						
13. Long-Term Care						
Hospital						
14. Swing Beds						
15. Nursing Home SNF						
(Medicare Only)						
16. Nursing Home NF						
(Medicaid Only)						
17. Nursing Home						
SNF/NF (dually						
certified MCare/Maid)						
18. Nursing Home-						
Licensed (Noncertified)						
19. ICF/IID						
20. Residential Hospice						
TOTAL	66	66	+14	0	0	80

^{*} Beds approved but not yet in service

^{**} Beds exempted under 10% / 3 yrs provision

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7. Section B, Need, Item I.a. (Psychiatric Inpatient Services-Service Specific Criteria-)

Please complete the following tables to determine psychiatric bed need (1).

The applicant has expanded and completed the requested tables and added a table inventorying bed complements by age and type of unit; please see the following pages.

	Population 2020	Gross Need Pop. X (30 beds/100,000)	Current licensed beds	Net Need
	Child/Adolescent 0-17	Child/Adolescent 0-17	Child/Adolescent 0-17	Child/Adolescent 0-17
Proposed Primary Service Area	252,312	76	140	-64
Proposed Secondary Service	202,012	7.0	2.0	<u> </u>
Area	148,338	45	0	45
Total				
	400,650	120	140	-20

	Population 2020	Gross Need Pop. X (30 beds/100,000)	Current licensed beds	Net Need
	Adults 18-64	Adults 18-64	Adults 18-64	Adults 18-64
Proposed Primary Service Area	593,476	178	N.A.	N.A.
Proposed Secondary Service Area	394,720	118	N.A.	N.A.
Total	988,196	296	See Below	See Below

	Population 2020	Gross Need Pop. X (30 beds/100,000)	Current licensed beds	Net Need
	Geriatric 65+	Geriatric 65+	Geriatric 65+	Geriatric 65+
Proposed Primary Service Area	135,234	41	N.A.	N.A.
Proposed Secondary Service			1,000	
Area	136,954	41	N.A.	N.A.
Total	272,188	82	See Next Page	See Next Page

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	Population 2020	Gross Need Pop. X (30 beds/100,000)	Current licensed beds	Net Need
	Adult & Geri 18+	Adult & Geri 18	Adult & Geri 18	Adult & Geri 18
Proposed Primary Service Area	728,710	219	604	-385
Proposed Secondary Service Area	531,674	160	278	-118
Total	1,260,384	378	882	-504

Crestwyn's application, as directed by the State Health Plan review criteria, projected bed need based on total licensed inpatient behavioral beds for all patients, not by three age cohorts. This is because there is insufficient information in the Joint Annual Report to permit utilization analysis and projection by all three age cohorts, as this question seeks to do. To quote Standard 1 in the State Health Plan (found on application page 19):

...the applicable JAR form does not provide occupancy rates by age category. Health Planning believes developing determination of need formulas specific to each age category is not possible at this time due to these limitations in available data.

Specifically, separate licensed bed assignments are not required for adult and geriatric adults; adult age mix changes according to the needs of the market, for many providers. To try to provide some information to the reviewer, the applicant has added a fourth table (above on this page) combining beds of the two adult cohorts.

In addition, on the following page the applicant provides a new table showing the service area's <u>staffed</u> behavioral bed complements by age cohort and by use (psychiatric or substance abuse), with a comparison to the licensed bed complements of the facilities. Bed staffing was derived from page 38 of the 2016 Joint Annual Reports of area providers.

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			SOLO SOUR AMINOR INCOOLS										
Chilc	Children & Youth (0-17)	17)	PΦ	Adult (18-64)		Gerî	Geriatric (65+)		Grand	Grand Total, Staffed	Pa	Lice	Licensed
Sub Abuse	Psych	Total	Sub Abuse	Psych	Total	Sub Abuse	Psych	Total	Sub Abuse	Psych	Total Staffed	Total Licensed	Licensed Beds Unvailable for IP
5	81	86	31	172	203	0	48	48	36	301	337	345	80
0	0	0	0	55	55	0	0	0	0	55	55	111	56
0	0	0	0	77	77	0	37	37	0	114	114	114	0
0	34	34	0	0	0	0	0	0	0	¥	8	34	0
0	20	20	0	20	20	0	0	0	0	40	40	80	40
0	0	0	0	30	30	0	0	0	0	90	30	90	30
2	135	140	31	354	385	0	82	92	36	574	610	744	134
0	0	0	0	0	0	0	7	7	0	7	7	12	2
0	0	0	0	150	150	0	0	0	0	150	150	187	37
0	0	0	0	22	22	0	0	0	0	22	22	22	0
0	0	0	0	18	18	0	0	0	0	18	18	25	7
0	0	0	0	0	0	0	16	16	0	16	16	16	0
0	0	0	0	0	0	0	16	9	0	16	16	16	0
0	0	0	0	190	190	0	39	39	0	229	229	278	49
ĸ	135	140	34	544	575	0	124	124	36	803	839	1022	<u>≅</u> 1′
	Sub Abuse 5 5 6 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Psych 81 0 0 34 20 0 0 0 0 0 0 0 0 0 135	Psych Total 81 86 0 0 0 34 34 20 20 0 0 0 136 140 0 0 0 0 0 0 0 0 0 136 140	Psych Total Sub Abuse 81 86 31 0 0 0 0 0 0 20 20 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 135 140 31	Psych Total Sub Abuse Psych 81 86 31 172 0 0 0 55 0 0 0 77 20 20 0 77 0 0 0 20 0 0 0 30 0 0 0 30 0 0 0 150 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Psych Total Sub Abuse Psych Total 81 86 31 172 203 0 0 0 55 55 0 0 0 77 77 20 20 0 0 0 20 20 0 0 0 0 0 0 30 30 135 140 31 364 385 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <	Psych Total Sub Abuse Psych Total Sub Abuse 81 86 31 172 203 0 0 0 0 0 0 0 0 0 0 77 77 0 20 20 0 0 0 0 20 20 0 20 0 0 0 0 0 30 30 0 0 0 0 30 30 0 0 0 0 30 30 0 0 0 0 30 30 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <	Psych Total Sub Abuse Psych Total Sub Abuse Psych 81 86 31 172 203 0 48 81 86 31 172 203 0 48 90 0 0 77 77 0 0 0 10 0	Psych Total Sub Abuse Psych Total Sub Abuse Psych Total Total	Psych Total Sub Abuse Psych Total Sub Abuse Psych Total Sub Abuse Psych Total Sub Abuse 81 86 31 172 203 0 48 48 36 0 0 0 6 55 55 0 0 0 0 134 34 0 6 77 77 0 <td>Psych Total Sub Abuse Psych Total Sub Abuse Psych Total Sub Abuse Psych Total Sub Abuse Psych Psych<</td> <td>Paych Total Sub Abuse Paych Sub Abuse <t< td=""></t<></td>	Psych Total Sub Abuse Psych Total Sub Abuse Psych Total Sub Abuse Psych Total Sub Abuse Psych Psych<	Paych Total Sub Abuse Paych Sub Abuse Sub Abuse <t< td=""></t<>

Source: Joint Annual Reports, page 38
Notes:
1. Lakeside Behavioral Health JAR indicates that 8 of their 345 licensed beds are set up for crisis stabilization. These are not included in the 337 total beds shown in the table above.

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8. Section B, Need, Item 2.e Patients with Intellectual Disabilities (Psychiatric Inpatient Services-Service Specific Criteria-) Page 22

Please indicate where the applicant refers patients with Intellectual Disabilities for inpatient psychiatric treatment in the proposed service area.

If unable to accept this type of patient, the applicant must often refer the patient out of State for lack of a provider in the service area with available capacity. The last such referral was to an Atlanta facility. To place such patients, Crestwyn staff members work with patient families and with community agencies such as BSTN (Behavioral Services of Tennessee), Youth Villages, and Alliance Healthcare Services.

In its admission decisions, Crestwyn follows all guidelines of EMTALA (the Emergency Medical Treatment and Labor Act) to ensure patients' access to emergency care regardless of ability to pay. Federal law requires hospitals that participate in Medicare and offer emergency care to provide a medical screening examination when a request is made for examination or treatment for any emergency medical condition (including active labor), without regard to the patient's ability to pay. The hospital must then provide stabilizing care if possible; and if not, an appropriate transfer must be arranged.

9. Section B, Need, Item 2.f Medical Inpatient Transfer Agreements (Psychiatric Inpatient Services-Service Specific Criteria-) Page 23

It is noted the applicant has medical transfer agreements with Baptist and St. Francis. Please indicate their distance from the applicant.

Baptist Memorial Hospital Memphis is 14.0 miles from Crestwyn. St. Francis is 11.1 miles.

10. Section B, Need, Item 2.j Crisis Stabilization Units (Psychiatric Inpatient Services-Service Specific Criteria-) Page 24

It is noted the proposed service area has two TennCare designated Crisis Stabilization teams-Youth Villages and Alliance. Please provide a brief overview of each Crisis Stabilization Service including the number of beds available.

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The Youth Villages Specialized Crisis Services staff provides assessment and evaluation of children and youth up to the age of 18, who are experiencing a psychiatric emergency. They are organized into seven areas that cover the entire State. They are designated by TennCare to provide services to TennCare patients across the State. Youth Villages has no crisis stabilization beds of its own at this point in time, but does operate six residential treatment homes across the State as well as group homes in Nashville and Memphis.

Alliance Healthcare Services is the largest provider of outpatient mental health are in Shelby County, where it operates 55 crisis intervention beds and a continuum of crisis services. Their services also include outpatient medicine management; individual, group and family therapy; care coordination, a continuum of housing services. They are also a designated TennCare provider.

11. Section B, Need, Item 3 Incidence and Prevalence (Psychiatric Inpatient Services-Service Specific Criteria-) Page 24

Please use incidence and prevalence data from the following Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) web-site to respond to the Incidence and Prevalence Criteria: https://www.tn.gov/behavioral-health/research/data--research--and-planning/county-and-regional-behavioral-health-prevalence-dashboard.html In your response, please also compare the proposed service area to the statewide incidence and prevalence trends.

The TDMHSAS website and related links provide a wealth of data on indicators of incidence and prevalence of mental health and substance abuse behaviors. However, it does not appear to offer information that would make that data relevant to establishing the need for this particular type of inpatient project.

TDMHSAS's 2017 Data Book for Behavioral Health Indicators for Tennessee and the United States, and its 2017 Tennessee Behavioral Health County and Region Services Data Book, compare indicators in the Department's seven Planning and Policy Regions (PPR's) to Statewide and national indicators. Crestwyn is in PPR #7, which consists of Shelby County, Crestwyn's primary service area. Crestwyn also serves PPR#6, which is the rest of West Tennessee. Unfortunately, PPR data on hospital admissions trends is limited to facilities owned by or under contract to the Department. The data do not include trends at private hospitals, which in PPRs 6 and 7 provide the great majority of behavioral health bed utilization. Almost all data in the books pertains to behaviors known to carry risks of mental illness.

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The applicant's review of these sources suggests that Tennessee, and PPRs 7 and 8, do not vary greatly from other areas, in their indicators. For perspective, selected pages from these books are attached after this page. They identify areas of concern in which Tennessee is higher or lower in rankings against other States.

In addition, the applicant noted that rates of admission to TDMGSAS-affiliated hospitals in PPRs 6 & 7 (this project's secondary and primary service areas, respectively) were lower than the Tennessee average. The following facts were also identified in the 2017 Tennessee Behavioral Health County and Region Services Data Book. Data cited are for 2016.

<u>Table 38, Chart 30 and Table 44A</u>: For persons age 18+, 2016 admissions (to TDMHSAS-affiliated hospitals) were 2.3 per thousand population Statewide, but only 2.1 in Shelby County and 1.7 in West Tennessee excluding Shelby County,

<u>Table 39</u>: Admissions by gender were 66.4% male and 33.6% female for PPR 7 (Shelby County) and 65.1% male and 34.9% female for PPR 6 (West Tennessee excluding Shelby).

<u>Table 40</u>: In PPR 7, 18.3% of admissions were 18 to 25 years of age; 81.7% were 26 or older. In PPR 6, those percentages were 16.8% and 83.2%, repectively.

Substance Abuse Services Mental Health & Department of

County and Region Services Data Book 2017 Tennessee Behavioral Health

September 2017

Division of Planning, Research and Forensics Xinqing Deng, MD, MPH and Rachel L. Jones Office of Research Prepared by:

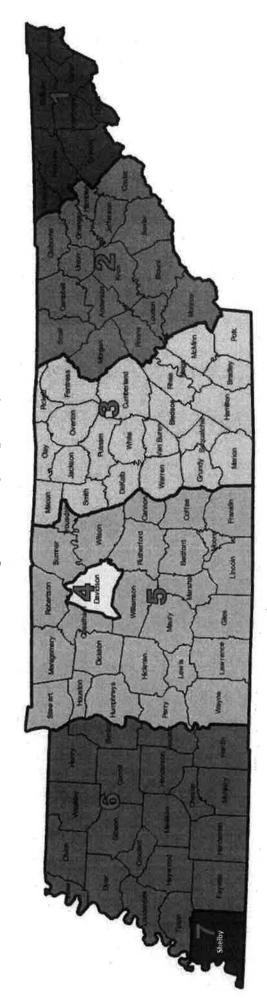
Contact: Karen Edwards, Ph.D., Research Divertor Contact: Karen Edwards@tracox Karen.Edwards@tracox 8810

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TDMHSAS Planning and Policy Regions (PPR)

Department of Mental Health & Substance Abuse Services



Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi, Washington counties Region 1: Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Jefferson, Hamblen, Knox, Louden, Monroe, Morgan, Roane, Scott, Sevier, Region 2:

Union counties

Bledsoe, Bradley, Clay, Cumberland, DeKalb, Fentress, Grundy, Hamilton, Jackson, Macon, Marion, McMinn, Meigs, Overton, Pickett, Region 3:

Polk, Putnam, Rhea, Sequatchie, Smith, Van Buren, Warren, White counties

Davidson County Region 4: Bedford, Cannon, Cheatham, Coffee, Dickson, Franklin, Giles, Hickman, Houston, Humphreys, Lawrence, Lewis, Lincoln, Maury, Region 5:

Marshall, Montgomery, Moore, Perry, Robertson, Rutherford, Stewart, Sumner, Trousdale, Wayne, Williamson, Wilson counties

Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Region 6:

Madison, McNairy, Obion, Tipton, Weakley counties

Shelby County Region 7:

September 2017



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2. Quick facts

The "quick facts" section highlights indicators for which Tennessee ranks at the top or the bottom when compared with other states' most recent data or for which an interesting pattern over years was observed.

These highlights have been categorized in two groups: 1) indicators with a high rank, a low prevalence or improvements in ranking over years; and 2) indicators with a low rank, a high prevalence or decreases in ranking over years.

Indicators with low prevalence or positive outcomes

Tennessee had a lower prevalence of current alcohol users when compared with other states. The

For most substance abuse indicators, Tennessee rankings were consistently in the top 10 or middle 30.

use in the past month than the national average among youth and adults over the most recent five years of data available.
Tennessee was in the top ten states with a lower prevalence of individuals with an alcohol use disorder (dependence or abuse of alcohol) in the past year. The percentages of individuals with an alcohol disorder in the past year in Tennessee were lower than national average levels over the recent five years.
The percentage of people not receiving treatment for a substance use disorder was lower than the national average for all age groups, particularly for adults ages 26+.
In addition, Tennessee decreased its prevalence rates in nonmedical use of pain relievers in the past year and needing but not receiving substance abuse treatment for illicit drugs in the past year.
Tennessee was among the top ten states with a lower prevalence of marijuana use in the past month, and also with a lower average annual incidence of marijuana (first use of marijuana).
Tennessee improved its ranking for youth in grades 9-12 who smoked a cigarette on at least one day in the past 30 days in both 2013 and 2015 YRBS survey, moving up its rank from the bottom 20% to the middle 60% of states. The prevalence of tobacco product use in the past month of cigarette use in the past month decreased significantly among youth (ages 12 - 17).
The only mental health indicator where Tennessee had a lower percentage compared to other states

was for youth ages 12-17 who had at least one major depressive episode in the past year.



Indicators with high prevalence or negative outcomes in Tennessee

- Although improving over the most recent five years, the prevalence of tobacco product use or cigarette use in the past month was still higher than national average level.

 Tennessee's ranking are consistently in the bottom 10 or middle 30 with a higher prevalence that
- Tennessee's ranking are consistently in the bottom 10 or middle 30 with a higher prevalence than national average level for most mental health indicators, particularly for adults ages 26+.
- Tennessee ranked among the bottom ten states for children and youth (ages 2- 17) who received a mental health diagnosis by a doctor (e.g., autism, developmental delays, depression, anxiety, ADD/ADHD, or behavioral/conduct problems).
- Tennessee ranked among the bottom 20% of states for a few indicators addressing behavioral health issues for youth in high school (grades 9-12) during 2013. These indicators include:
 - the use of methamphetamines;
 - the use of non-medical prescription drugs during their lifetime;
 - attempted suicides that resulted in an injury that had to be treated by a doctor or nurse.
- In 2015 BRFSS survey, Tennessee was in the bottom 10 states with the highest number of reported poor mental health days for adults (18+ years).
- In 2015 BRFSS survey, Tennessee ranked among the bottom 10 states with a high prevalence of adults (18+ years) who are limited in any activities because of physical, mental or emotional problems.
- A higher percentage of adults (26+ years) in Tennessee reported to be suffering from any mental illness in the last year than national average level and Tennessee ranks the bottom 10 states over the recent five years.





The following table highlights the indicators where Tennessee ranks in the bottom 10 states, indicating a high prevalence of substance use and mental health issues, when compared with other states based on the most recent data available.

Table 2. Tennessee ranks among the bottom 10 states in:

Indicator	Children/ Age	Youth in Grades	Adults Age 18+	Adults Age 26+
Used methamphetamines one or more times during their lifetime.	2-17	9-12	101	20+
Used prescription drugs one or more times in their life without a doctor's prescription.		✓		
Children with a mental health diagnosis.	√			
Youth who attempted suicide that resulted in an injury.	K	✓		
Youth who were bullied on school property in the past 12 months		✓		
Adults who had serious thoughts of suicide.				
Adults who are limited in any activities because of physical, mental or emotional problems.			√	
Number of reported poor mental health days.			√	
Adults with any mental illness in past year.				√



The following table highlights the indicators where Tennessee ranks among the top 10, indicating a lower prevalence of substance use and mental health issues, when compared with other states (based on the most recent data available).

Table 1. Tennessee ranks among the top 10 states with low prevalence in:

Tubic 1. Tellifessee falliks alliong				
Indicator	Youth Age 12-17	Young adults Age 18-25	Adults Age 18+	Adults Age 26+
Used alcohol in the past month.	✓	✓	✓	✓
With alcohol use disorder in past year.	✓	✓	✓	✓
Needing but not receiving substance abuse treatment for alcohol.			✓	✓
Used illicit drugs in past month.	✓	✓	✓	✓
First use of marijuana	✓	✓	✓	✓
Used marijuana in the past month.	✓		✓	✓
Used marijuana in the past year.	✓	✓		
Had at least one major depressive episode in past year.	✓			

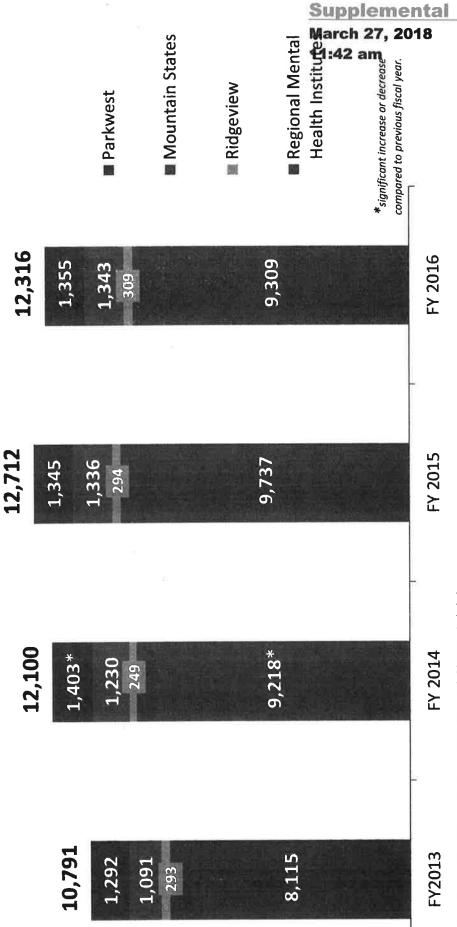
Please note that Tennessee ranks in the middle or bottom 20% for most mental health indicators; see next page.

#1

Table 37. TDMHSAS-funded admissions to psychiatric hospitals

	FY2013	FY2013 FY 2014 FY 2015	FY 2015	FY 2016
Regional mental health institutes	8,115	9,218	9,737	608'6
Private psychiatric hospitals that contract with TDMHSAS	2,676	2,882	2,975	3,007
Statewide number of admissions	10,791	12,100	12,712	12,316

Chart 29. TDMHSAS-funded admissions to regional mental health institutes and private psychiatric hospitals that contract with TDMHSAS



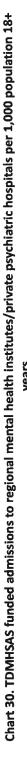
Data source: TDMHSAS Division of Hospital Services. Patients age 18 and older were included.

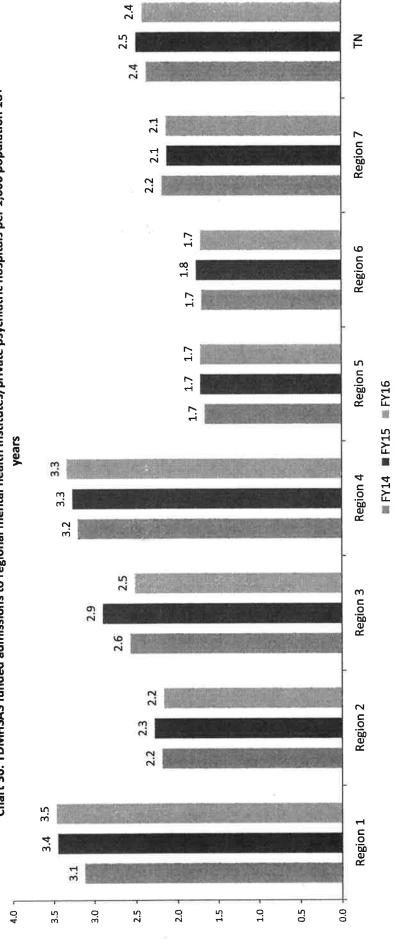
Please note that Lakeshore Mental Health Institute closed with the end of FY2012; TDMHSAS started contracting with private psychiatric hospitals in FY2012.

Table 38. TDMHSAS-funded admissions to regional mental health institutes and private psychiatric hospitals that contract with TDMHSAS

Department of Mental Health & Substance Abuse Services

					The second secon			The second second second	Company of the last
TDMHSAS Region	Tennessee	PPR 1	PPR 2	PPR 3	PPR 4	PPR 5	PPR 6	PPR 7	N/A*
EV14	12,100	1,299	2,100	1,972	1,706	2,082	828	1,523	290
F1 14	%00T	10.74%	17.36%	16.30%	14.10%	17.21%	6.84%	12.59%	4.88%
FV1E	12,712	1,435	2,188	2,220	1,742	2,144	829	1,480	644
LIT	100%	11.29%	17.21%	17.46%	13.70%	16.87%	6.76%	11.64%	2.07%
2446	12,316	1,418	2,080	1,922	1,778	2,145	833	1,485	655
LITO	700%	11.51%	16.89%	15.61%	14.44%	17.42%	89.79	12.06%	5.32%





Data source: TDMHSAS Division of Hospital Services.

County and Region Services Data Book 2017 Behavioral Health

^{*}Data note: N/A includes admission from out of state as well as admissions with missing county of residence; PPR=TDMHSAS Planning and Policy Region.

Department of Mental Health & Substance Abuse Services

Table 43. Number of admissions and rate per 1,000 population 18+ years by Planning and Policy Regions and counties

Marcon 17 10 11 12 13 14 14 14 14 14 14 14
Marchine 1
11 * 10 * 10 * 10 * 10 * 10 * 10 * 10 * 10 * 10 * 10 10
105 1.7 29 1.7 26 1.5 29 20 20 20 20 20 20 20
105 3.0 4.9 2.2 6.6 2.8 Rutherford 357 1.6 388 1.7 407 31 3. 1.0 3.4 1.17 2.8 44 3.3 3.4 3.6 2.5 4
115 2.5 140 3.4 117 2.8 Stewart 16 1.5 1.2 1.0 1.0 1.1 2. 2. 2. 3.1 2. 2. 3.1 1.1 2. 3. 3. 3. 3. 3. 3. 3.
31 33 30 3.2 2.9 3.1 11
11 * 18
100 * 44 33 49 347 346 2.7 Wayne 22 15 15 26 13 30 30 30 30 30 30 30
105 14 33 49 37 36 27 Williamson 95 0.6 113 0.7 90 0.0 105 1.8 1.36 2.3 1.40 2.4 Williamson 1.25 1.3 1.39 1.4 1.62 1.7 108 4.1 1.08 4.2 3.8 3.9 3.9 4.0 1.2 4.2 3.3 3.4 3.1 108 1.4 2. 2. 3.16 2.3 1.6 2.3 3.9 4.0 2.5 3.3 3.4 3.5 109 1.4 2. 2. 3.1
1.05 1.8 1.36 2.3 1.40 2.4 2
1 1 3 4.1 1 1 4 4.2 3 3.4 1 2 3 4.1 1 4 4.0 3 3 2.9 1 3 4.1 1 4 4.0 3 3 2.9 1 4 5 4 3 3 2.9 1 4 5 4 3 3 3.9 1 4 5 4 3 3 3.9 1 4 5 4 3 3 3 3 1 5 5 5 5 5 3 3 1 5 5 5 5 5 3 1 5 5 5 5 5 3 1 5 5 5 5 5 5 1 5 5 5 5 5 1 5 5 5 5 5 1 5 5 5 5 1 5 5 5 5 1 5 5 5 5 1 5 5 5 5 1 5 5 1 5 5 5 1 5 5
Fig. 2.0 1.7 46 4.0 33 2.9 Benton 28 2.2 42 33 34 1.4 * 1.1 * 5 * * 1.4 * 1.1 * 5 * * 2.8 2.2 3.8 2.9 3.1 2.9 2.1 2.2 3.1 2.9 2.1 2.2 3.1 2.9 2.1 2.2 3.1 2.1 2.2 3.1 3.2 2.1 3.2 3.2 3.2 2.2 3.3 3.4 3.4 3.1 3.1 3.2 3.4 3.1 3.2 3.2 3.4 3.1 3.2 3.2 3.5 3.2 3.2 3.3 3.6 3.2 3.3 3.7 3.2 3.3 3.8 3.2 3.3 3.8 3.2 3.3 3.8 3.2 3.3 3.8 3.2 3.3 3.8 3.2 3.3 3.8 3.2 3.3 3.8 3.2 3.3 3.8 3.2 3.3 3.8 3.2 3.3 3.8 3.2 3.3 3.8 3.2 3.3 3.8 3.2 3.3 3.8 3.2 3.3 3.8 3.2 3.3 3.8 3.2 3.3 3.8 3.2 3.3 3.8 3.3 3.3 3.8 3.3 3.3 3.8 3.3 3.3 3.8 3.3 3.3 3.8 3.3 3.3 3.8 3.3 4.3 4.3 4.3 5.8 3.3 3.3 5.8 3.3 3.3 5.8 3.3 3.3 6.9 3.3 3.3 7.0 3.3 3.3 7.0 3.3 3.3 8.8 3.3 3.3 9.8 3.3 3.3 9.8 3.3 3.3 9.8 9.8 3.3 9.8 3.3 9.8 3.3 9.8 3.3 9.8
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Fig. 2.2 SS 2.9 3.0 Crockett 11 ** 9 ** 9 1.06 2.2 1.4 36 1.7 Decatur 13 ** 2.3 2.5 1.2 1.07 3.2 1.740 3.3 1.778 3.3 1.764 3.2 1.740 3.3 1.778 3.3 1.78 3.1 1.79 2.5 1.80 2.3 1.78 3.1 1.79 2.1 2.2 2.5 2.5 2.5 1.79 3.1 1.79 3.1 2.7 2.5 1.10 4.5 1.5 4.5 1.8 2.1 2.1 1.10 4.1 2.1 2.2 3.1 3.1 3.1 3.1 3.1 3.1 1.10 4.1 3.1 3.1 3.1 3.1 3.1 3.1 1.11 4.1 3.1 3.1 3.1 3.1 3.1 3.1 3.1 1.11 4.1 3.1 3.1 3.1 3.1 3.1 3.1 3.1 1.11 4.1 3.1 3.1 3.1 3.1 3.1 3.1 3.1 1.11 4.1 3.1 3.1 3.1 3.1 3.1 3.1 3.1 1.11 4.1 3.1 3.1 3.1 3.1 3.1 3.1 3.1 1.11 4.1 3.1 3.1 3.1 3.1 3.1 3.1 3.1 1.11 4.1 3.1 3.1 3.1 3.1 3.1 3.1 3.1 1.11 4.1 3.1 3.1 3.1 3.1 3.1 3.1 3.1 1.11 4.1 3.1 3.1 3.1 3.1 3.1 3.1 3.1 1.11 4.1 3.1 3.1 3.1 3.1 3.1 3.1 3.1 1.11 4.1 3.1 3.1 3.1 3.1 3.1 3.1 3.1 1.11 4.1 3.1 3.1 3.1 3.1 3.1 3.1 3.1 1.11 4.1 3.1 3.1 3.1 3.1 3.1 3.1 3.1 1.11 4.1 3.1 3.1 3.1 3.1 3.1 3.1 3.1 1.11 4.1 3.1 3.1 3.1 3.1 3.1 3.1 3.1 1.11 4.1 3.1 3.1 3.1 3.1 3.1 3.1 3.1 1.11 4.1 3.1 3.1 3.1 3.1 3.1 3.1 3.1 3.1 1.11 4.1 4.1 4.1 4.1 4.1 4.1 4.1 4.1 4.1 4.1 4.1 1.11 4.1 4.1 4.1 4.1 4.1 4.1 4.1 4.1 4.1 4.1 1.11 4.1
136 1.0 29 1.4 36 1.7 Decatur 13 * 23 2.5 1.2 1,964 2.6 2,216 2.9 1,921 2.5 Doeatur 53 1.8 56 1.9 54 1.5 1) 1,704 3.2 1,740 3.3 1,778 3.3 Cibson 46 1.2 50 1.9 54 1.9 54 1.8 56 1.9 54 1.8 48 1.9 54 1.9 54 1.9 54 1.2 52 1.4 48 56 1.9 54 48 48 48 48 48 48 48 48 48 48 48 48 48 49 </td
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1) 1,704 3.2 1,740 3.2 1,778 3.3 Fayette 2.5 0.8 3.0 1.0 3.9 1 28 2.2 90 2.6 80 2.3 46 1.2 5.1 48 48 n 45 1.5 45 1.8 6.7 2.4 1.8 4.8 1.2 3.1 1.2 3.1 1.2 3.2 1.4 48 43 48 48 48 48 48 48 48 48 48 1.2 48 1.2 2.4 48 43 44 43 43 44 44 44 44 44 44 44 44 44 44 45 45 45 45 44 45 <t< td=""></t<>
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34 3.1 19 1.7 27 2.5 Hardeman 111 5.4 112 5.4 130 45 1.5 45 1.8 54 1.8 Hardin 31 1.5 36 1.8 43 126 3.1 1.2 3.1 1.7 3.1 1.5 36 1.8 43 87 2.2 1.00 2.5 44 1.0 2.2 1.0 2.2 1.0
45 1.5 45 1.8 46 Hardin 31 1.5 36 1.8 43 43 126 3.1 127 3.1 2.4 1.4 2.4 1.7 3.1 1.5 3.1 1.5 3.1 1.5 1.6 1.7 1.5 1.6 2.5 1.0 2.5 1.0 2.5 1.0 2.5 1.0 2.5 1.0
126 3.1 127 3.1 97 2.4 Haywood 2.3 1.7 15 1.1 2.2 87 2.2 86 2.2 100 2.5 Henderson 40 1.9 35 1.6 25 67 2.9 58 2.9 2.4 Henderson 40 1.9 35 1.6 25 40 2.1 70 3.7 41 2.1 Henderson 40 1.9 35 1.6 25 40 2.1 70 3.7 41 2.1 Henderson 40 1.9 30 1.2 24 40 2.1 70 3.7 41 2.1 Lake 8 * 5 * 5 4 5 * 5 * 5 * 5 * 5 * 5 * 5 * 5 * 4 5 1 4 5 * 4
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71 2.2 73 2.4 Henry 26 10 30 12 24 67 2.9 58 3.9 Lake 8 * 5 * 5 * 5 40 2.1 70 3.7 41 2.1 Lauderdale 30 1.4 38 1.8 5 * 5 115 5 4 5 5 11 4 38 1 4 5 1 11 2 1 1 4 1 1 4 1 1 4 1 1 4 4 1 1 4 1 1 4 4 1 1 4 4 1 4 4 1 4 4 1 4
67 2.9 58 3.9 Lake 8 * <5 * <5 40 2.1 70 3.7 41 2.1 Lauderdale 30 1.4 38 1.8 55 11 * 10 * 24 3.8 Madison 149 2.0 156 2.1 115 2.1 115 2.1 115 2.1 115 2.1 115 2.1 115 2.1 115 3.1 42 3.1 42 3.1 42 3.1 42 3.1 42 3.1 42 3.1 42 3.1 42 3.1 42 3.1 42 3.1 42 3.1 42 3.1 42 3.1 42 3.1 42 3.1 42
40 2.1 70 3.7 41 2.1 Lauderdale 30 1.4 38 1.8 55 11 * 10 * 24 38 2.4 Madison 149 2.0 156 2.1 115 32 2.3 28 2.0 34 2.4 McNairy 53 2.6 42 2.1 42 43 2.1 59 1.9 Obion 26 1.1 29 1.2 31 24 0.9 39 1.5 36 1.4 Weakley 44 1.6 39 1.4 30.5 180 2.7 17 2.6 1.4 1.5 2.1 1.48 30.5 180 2.7 17 859 1.8 83.5 1.4 30.5 180 2.7 1.7 859 1.8 83.5 1.4 83.5 180 2.7 1.4 1.5 2.7 1.480<
Houston 11 * 10 * 24 38 Madison 149 2.0 156 2.1 115 Humphreys 32 2.3 2.8 2.0 34 2.4 McNairy 53 2.6 42 2.1 42 Lawrence 67 2.1 65 2.0 59 1.9 Obion 26 1.1 29 1.2 42 Lewis 43 6.6 2.9 3.6 1.8 Weakley 44 1.6 39 1.4 30.5 Marshall 38 1.6 49 2.0 3.2 1.3 Region 7 (Shelby) 45.2 2.2 1.480 2.1 1.480 Montgomery 133 1.4 1.2 2.1 1.4 2.2 1.480 2.1 1.480 Montgomery 133 1.4 1.5 2.1 1.4 2.2 1.4 2.2 1.4 2.2 1.480 2.1 1.480 2.1
32 2.3 28 2.0 34 2.4 Mochairy 53 2.6 42 2.1 42 2.1 42 2.1 42 2.1 42 2.1 42 2.1 42 2.1 31 1.3 1.4 1.3 1.4 1.3 1.4
67 2.1 65 2.0 59 1.9 Obion 26 1.1 29 1.2 31 43 4.6 2.9 3.1 2.6 2.8 Tipton 40 0.9 45 1.0 55 - 1 24 0.9 3.9 1.5 3.6 1.4 Weakley 44 1.6 39 1.4 30 - 1 180 2.7 1.7 859 1.8 833 C 180 2.7 1.7 859 1.8 833 C 193 1.4 2.5 1.6 N/A 583 - 649 B 1.2 * <5
43 4.6 29 3.1 26 2.8 Tjoton 40 0.9 45 1.0 55 - 1 24 0.9 39 1.5 36 1.4 Weakley 44 1.6 39 1.4 30 - 1 180 2.7 1.7 859 1.8 833 / 1 180 2.7 1.7 859 1.8 833 / 1 193 1.4 2.5 1.6 N/A 583 - 649 / 2 4 5 * 45 * 45 2.4 12,646 2.4 12,284
24 0.9 39 1.5 36 1.4 Weakley 44 1.6 39 1.4 30.5 180 2.7 1.7 2.6 142 2.1 Region 7 (Shelby) 1,522 2.2 1,480 2.1 1,483 193 1.4 198 1.4 225 1.6 N/A 583 - 635 - 6493 <5
38 1.6 49 2.0 32 1.3 Region 6 827 1.7 859 1.8 833K 180 2.7 177 2.6 142 2.1 Region 7 (Shelby) 1,522 2.2 1,480 2.1 1,48th 193 1.4 198 1.4 225 1.6 N/A 583 - 635 - 6495 3 <5
180 2.7 177 2.6 142 2.1 Region 7 (Shelby) 1,522 2.2 1,480 2.1 1,480 193 1.4 198 1.4 225 1.6 N/A 583 - 635 - 6493 - <5
193 1.4 198 1.4 225 1.6 N/A 583 - 635 - 649 3
<5 * <5 * <5 * Tennessee 12,031 2.2 12,646 2.4 12,284

Data note: <5 = number of admissions less than 5 but greater than or equal to 1; 0 events reported if applicable; *Rates not reported for admissions <20; PPR=TDMHSAS Planning and Policy Region. N/A includes admissions from individuals "out of state" or where the county of residence was unknown or not collected.

County and Region Services Data Book 2017 Behavioral Health

12. Section C, Need, Item 1 a., (Project Specific Criteria-Psychiatric Inpatient Services) B. 2. Service Area Demographics and Section B. Need. Item 4.A Service Area Demographics

Please complete the following chart for each county in the proposed service area.

Demographic Data	Service Area Total	State of TN Total
0-17 Population-2018		
0-17 Population-2020		
0-17 Population % Change		
0-17 Population % of Total Population		
65+ Population-2018		
65+ Population-2020		
65+ Population % Change		
65+ Population % of Total Population		

Please see the applicant's table on the following page.

	Supplem	Supplemental Table:	2018 and 2	e: 2018 and 2020 Service Area Pol Response to Reviewer's Question	Area Popula Question 12	2018 and 2020 Service Area Population, 0-17 and 65+sponse to Reviewer's Question 12	and 65+		
					0-17 Percent of Total				65+ Percent of Total
Primary Service Area Counties	Total Population 2020	0-17 Population 2018	0-17 Population 2020	0-17 % Change 2018 - 2020	County Population 2020	65+ Population 2018	65+ Population 2020	65+ % Change 2018 - 2020	County Population 2020
Shelby / PSA Total	981,022	249,747	252,312	1.0%	25.7%	125,389	135,234	7.9%	13.8%
SSA									
Benton	16,741	3,045			17.8%		4,568		
Carroll	28,782	6,105			21.0%		699'9		
Chester	18,978	3,913			20.4%		3,080		18.9%
Crockett	15,080	3,570					3,079		
Decatur	12,077	2,410					3,263		
Dyer	39,872		1				150,1	5.5%	
Fayette	48,510				20.6%		11,171		
Gibson	52,438								
Hardeman	27,278		5,143					5.8%	
Hardin	26,783						6,681		
Haywood	18,128		4,178	-2.5%	23.0%		3,644		
Henderson	30,298		6,898		22.8%		5,959		
Henry	34,055		6,777	-1.0%			8,959	6.2%	
Lake	8,579		1,187	-1.7%	13.8%		1,399	4.6%	16.3%
Lauderdale	29,186		6,580		22.5%		4,578	5.9%	15.7%
McNairy	27,760		5,860	-1.0%	21.1%			6.2%	22.8%
Madison	106,352	25,039	25,201	%9:0	23.7%				
Obion	31,559								
Tipton	71,196		17,157						15.5%
Weakley	36,360			%9:0-	19.2%		7,119	5.2%	
Crittenden (AR)	49,039		12,713			6,323	6,587	4.2%	
Lawrence (AR)	16,780		3,601	-2.5%	21.5%				
DeSoto (MS)	179,683	46,645	47,316	1.4%	26.3%	N	N	7.3%	
Marshall (MS)	35,891	7,677	7,368	-4.0%		5	6,035		
Benton (MS)	8,324		1,818	-4.2%	21.8%		1,373	-1.2%	
SSA Total	969,729	221,800	221,154		22.8%	166,319	177,421	6.7%	18.3%
PSA + SSA Total	1,950,751		473,466		24.3%		312,655	7.2%	16.0%
State of TN Total	7,112,424	1,593,359	1,615,456		22.7%	1,175,938	1,267,962	7.8%	17.8%
TOO ! DOWN	O	2700							

Sources: TDOH Population Projections, 2015.

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- 13. Section B, Need, Item 6. Composition of Services (Psychiatric Inpatient Services-Service Specific Criteria-) Page 26
 - a. It is noted Crestwyn's 10.3 day average length of stay is slightly below the average for Memphis psychiatric hospitals as reported in their 2016 JARs (11.0) and well below the average length of stay for rural West Tennessee behavioral units and hospitals (23.0). However, it appears the West Tennessee average length of stay of 23.0 is possibly a result of Western Mental Health Institute which may have longer lengths of stay. Please clarify.

If Western Mental Health Institute is excluded from the calculation of ALOS for rural West Tennesee providers, the rural area average was approximately 8 days. Those providers' length of stay varied between 6 and 29 days. The total service area's average length of stay, again excluding WMHI, was 10 days--the same as Crestwyn's.

b. Also, please discuss the differences between Memphis Mental Health Institute (MMHI) and Western Mental Health Institute (WMHI) in terms of length of stays and services available. Information may be obtained at the following web-site: https://www.tn.gov/behavioral-health/hospitals.html

MMHI offers 55 beds in two short-term care units; its last reported average length of stay was 12 days. It is a State-owned facility that is responsible primarily for Memphis area residents. It takes both voluntary and involuntary admissions; most of its its patients have a severe and persistent mental illness and are taken in on an emergency, involuntary basis. Its patients are typically not served by private hospitals and have no other resources for inpatient treatment.

WMHI is also a State-owned behavioral health hospital. It is located in Bolivar, Hardeman County, where it serves primarily West Tennessee residents who live outside of Shelby County. WMHI also differs in that it treats long-term as well as short-term patients. It has two short-term care units and four long-term care units with a total of 187 licensed beds, of which 150 are staffed. It offers services similar to those of MMHI, but it has a much longer average length of stay (49 days) due to its patient mix of short- and long-term patients.

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14. Section B, Need, Item 8. Services to High-Need Populations (Psychiatric Inpatient Services-Service Specific Criteria-) Page 26

Please indicate the percentage of 2017 inpatient admissions that were involuntarily committed to Crestwyn.

In 2017, Crestwyn had 355 involuntary admissions, which was 20.6% of its 1,724 total admissions last year.

- 15. Section B, Need, Item 9. Relationship to Existing Similar Services (Psychiatric Inpatient Services-Service Specific Criteria-) Page 27
 - a. Please indicate the 2017 licensed and staffed occupancies for 0-17, 18-64, and 65+ for Shelby County.

This data is not fully available in the Joint Annual Reports. The JAR for 2017 shows beds set up and staffed on a "typical" day but these are not the same as licensed beds. Beds for adults of all ages may vary at will within a total authorized adult complement, so 18-64 and 65+ utilization cannot be separately calculated. Occupancies on licensed beds for patients 0-17 of age, and for all adult patients combined, have been provided for the entire service area, in response to question #7 above.

b. Please discuss how the applicant's services differ from existing inpatient psychiatric services (e.g. specialized treatment of an age-limited group. Acceptance of involuntary admissions, and differentiation by payor mix) available in Shelby County.

Unlike some service area providers, Crestwyn serves all age groups (although currently children younger than 10 are not currently accepted). Crestwyn is one of only two private hospitals in Memphis with programs for all three major age cohorts. It is the smallest private inpatient facility in PPR 7. Crestwyn not only provides inpatient services; it also provides Intensive Outpatient Programs for adults and adolescents (mornings and evenings), and an adult partial hospitalization program. Crestwyn is very accessible, with a payor mix of 46.3% Medicaid/TennCare. Last year, involuntary admissions were 20.6% of its admissions. In 2017, Crestwyn's psychiatric inpatient beds became the most highly utilized in Shelby County.

Page Twelve March 26, 2018

16. Section B, Need, Item 12. Institution for Mental Disease Classification (Psychiatric Inpatient Services-Service Specific Criteria-) Page 29

The applicant states the proposed project will not adversely affect TennCare's cost-sharing with Federal Medicaid. However, the bed complement data chart on page 14 indicates the addition of 3 adult and geriatric psychiatric beds. Please clarify.

The hospital has an IMD classification. The project will expand child and adolescent bed complements (Federally defined as patients under 21 years of age) by 14 additional beds, while reducing total adult services by 2 beds (the net difference in bed changes for both adult psychiatric and adult dependency units). The net effect of the project will therefore be an increase in beds for children and youth.

- 17. Section B, Need, Item 16. Community Linkage Plan. (Psychiatric Inpatient Services-Service Specific Criteria-) Page 31
 - a. The support letters provided are noted. However, please provide any letters from physicians, mobile crisis teams, and managed care organizations in support of the application detailing instances of unmet need for psychiatric inpatient services in the proposed service area. If possible, please provide measurable instances of unmet need rather than providing broad statements.

Respectfully, the applicant cannot provide more specific letters detailing instances of unmet need or quantifying unmet needs. That is not what the supporting public is typically willing to do.

Not only business relationship issues with providers, and medical confidentiality issues, but also personal liability issues, are legitimate concerns to professionals when voicing their feelings about existing providers.

The letters that supportive community groups have provided for this application clearly document their personal experiences with trying to find adequate inpatient resources for persons in need of care.

Page Fourteen March 26, 2018

b. Please provide the applicant's proposed primary prevention initiatives in the community linkage plan that addresses risk factors leading to the increased likelihood of Inpatient Psychiatric Bed usage.

Crestwyn's role in that regard is very limited. As an acute care hospital, Crestwyn does not manage or undertake prevention initiatives focused on risk reduction for potential patients. However, inpatients who have been cared for at Crestwyn are offered a continuum of robust post-discharge support programs to reduce their risks of being re-admitted. For example, Crestwyn provides an adolescent intensive outpatient program ("IOP") weekday evenings, a partial hospital program ("PHP") for adults on weekday mornings, an adult IOP weekday evenings, and a daytime IOP weekday mornings. These provide former inpatients with continuing support that helps reduce their risks of recurring hospitalization.

18. Section B, Need, Item 18. Quality Control and Monitoring. (Psychiatric Inpatient Services-Service Specific Criteria-) Page 32

Please provide the referenced Crestwyn licensure surveys. In addition, please provide information on the surveys and quality improvement programs of psychiatric inpatient facilities the applicant owns or administers whether located in Tennessee or not.

Crestwyn's most recent accreditation survey report is provided at the end of this letter, together with surveys of Crestwyn's other two Tennessee psychiatric hospitals.

19. Section C. Economic Feasibility Item 1 (Funding), Page 48

The applicant refers to Attachment Section B-Economic Feasibility-1D and Attachment Section B-Economic Feasibility-1E. However, those attachments could not be located. Please clarify.

Those references were errors. This project has no construction component and neither referenced attachment is required. Attached following this page is a revised page 48 R deleting those references.

ECONOMIC FEASIBILITY

- 1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.
- A. All projects should have a project cost of at least \$15,000 (the minimum CON Filing Fee), (See application instructions for Filing Fee.)
- B. The cost of any lease, The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.
- C. The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.
- D. Complete the Square Footage Chart on page 8 and provide the documentation. Please note the Total Construction Cost reported on line 5 of the Project Cost Chart should equal the Total Construction Cost reported on the Square Footage Chart.

The Project Cost Chart is provided on the following page.

- E. For projects that include new construction, modification, and/or renovation documentation must be provided from a licensed architect or construction professional that support the estimated construction costs. Provide a letter that includes the following:
 - 1) A general description of the project;
 - 2) An estimate of the cost to construct the project; and
 - 3) A description of the status of the site's suitability for the proposed project;
 - 4) Attesting the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities in current use by the licensing authority.

Not applicable; the project involves no construction.

Page Fifteen March 26, 2018

20. Section B. Economic Feasibility Item D. (Projected Data Chart)

The Projected Data Chart for the total facility is noted. However, please also provide a Projected Data Chart for the proposed project (14 bed addition) only.

The applicant did not submit a Chart for the project because one was deemed unnecessary by HSDA management in a pre-application discussion. Due to the very small scope of this project, to be implemented in existing space in a small facility, one Projected Data Chart for the expanded hospital itself was considered adequately informative.

21. Section B, Economic Feasibility, Item 6.C. Page 60

a. The capitalization ratio of .5756 is noted. However, please multiply ${\bf x}$ 100 to calculate the capitalization ratio.

Attached following this page is a revised page 60R making that correction.

b. The applicant indicates Net Assets of \$11,668,504 and Long-Term Debt of \$15,827,658. However, those figures could not be located in the applicant financial documents. Please clarify.

Attached after this page is a copy of the hospital's balance sheet, with the appropriate lines marked.

C. Capitalization Ratio (Long-term debt to capitalization) — Measures the proportion of debt financing in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: (Long-term debt/(Long-term debt + Total Equity (Net assets)) x 100).

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

Net Assets \$11,668,504 Long Term Debt \$15,827,658 \$27,496,162

15,827,658/27,496,162 = .5756 XX 100 = 57.56

Source: Acadia Healthcare 10K for 2016 (audited)

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58,298.47 11,188.83

22,345.00

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1,924,408.82

CRESTWYN CONSOL Grashwyn Copredidated

0146 Crestwyn Holdings

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55,295,47 11,188,38

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1,446,549,87 19,288,748.24 3,848,98 23,719,142,09

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Yous Bulkungs Total Bulg and Lease Improvements Total Equipment Gross PPE

Total Land

Total Liabilities and Equity

Total Equity

Raport-Baleson Elond - Countifying Haymaded Sun. Dyr singuless Levis Duke 63-14-18 Sanc. 10-303-9 AM

Page Sixteen March 26, 2018

22. Section B, Economic Feasibility, Item 7, Page 61

Please complete the following chart for Year One of the proposed project. Please use the Project Only Projected Data Chart to obtain the gross revenue amount.

	Gross	% of Total
Payor	Revenue	Revenues
Medicare/Medicare Managed Care	\$932,447	22.5%
Medicaid/TennCare	\$1,918,769	46.3%
Commercial insurance/Other Mgd Care	\$1,147,946	27.7%
Self-Pay	\$33,154	0.8%
Charity Care	\$37,298	0.9%
Other	\$74,596	1.8%
Total	\$4,144,210	100.0%

23. Section B, Orderly Development, Item 1 (Transfer Agreements), Page 64

Your response to this item is noted. Please indicate if the applicant has transfer agreements with Memphis Mental Health Institute and Western Mental Health Institute.

The applicant does not have transfer agreements with those two hospitals.

24. Section B, Orderly Development, Item 1 (Transfer Agreements), Page 66

Please provide the referenced state licensure survey information in Attachment Section B-Orderly Development-4B.

This is being gathered for submittal under separate cover.

Page Seventeen March 26, 2018

25. Section B, Orderly Development, Item 4.C-6B (Transfer Agreements), Pages 67 and 68

It is noted the applicant did not answer questions on page 67 and 68 of the application. Please provide responses and provide replacement pages labeled 67R and 68R.

Attached following this page are the requested responses, on replacement pages 67R-68R.

26. Section B, Quality Measures

Please verify and acknowledge the applicant will be evaluated annually whether the proposal will provide health care that meets appropriate quality standards upon the following factors:

- (3) Quality. Whether the proposal will provide health care that meets appropriate quality standards may be evaluated upon the following factors:
- (a) Whether the applicant commits to maintaining staffing comparable to the staffing chart presented in its CON application;
- (b) Whether the applicant will obtain and maintain all applicable state licenses in good standing;
- (c) Whether the applicant will obtain and maintain TennCare and Medicare certification(s), if participation in such programs was indicated in the application;
- (d) Whether an existing healthcare institution applying for a CON has maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action shall be considered;
- (e) Whether an existing health care institution applying for a CON has been decertified within the prior three years. This provision shall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility;

C. Document and explain inspections within the past three survey cycles which have resulted in any of the following state, federal, or accrediting body actions: suspension of admissions, civil monetary penalties, notice of 23- ore 90-day termination proceedings from Medicare or Medicaid/TennCare, revocation/denial of accreditation, or other similar actions. (1) Discuss what measures the applicant has or will put in place to avoid similar findings in the future.

Crestwyn was licensed in 2016. No such events have occurred.

5. Respond to all of the following and for such occurrences, identify, explain, and provide documentation:

The applicant has made a good faith effort to respond to this question regarding the entities identified in its organization chart, to the best of its knowledge, information and belief. Due to the breadth of the question and a lack of definition of key terms, the applicant cannot represent that these responses are totally comprehensive, but no responsive information is being intentionally withheld. Because there is no central repository for the information sought, and because of the length of time some of the entities have been in existence, the applicant's responses are limited to the past 5 years as a reasonable look-back period.

A. Has any of the following:

- (1) Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);
- (2) Any entity in which any person(s) or entity with more than 5% ownership (direct of indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%; and/or
- (3) Any physician or other provider of health care, or administrator employed by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%...

B. Been subjected to any of the following:

(1) Final Order or Judgment in a State licensure action;

The applicant assumes for the purpose of this question that "state licensure action" refers to facility licensure. Crestwyn Behavioral Health, and/or its owners (Baptist Memorial Health Services, Inc.; AmiSub (SFH), Inc.; Acadia Crestwyn Holdings) have not been subjected to Final Order or Judgment in a state licensure action. The other entities in the chain of ownership do not hold a hospital license.

(2) Criminal fines in cases involving a Federal or State health care offense;

No.

(3) Civil monetary penalties in cases involving a Federal or State health care offense;
No.
(4) Administrative monetary penalties in cases involving a Federal or State health care offense;
No.
(5) Agreement to pay civil or monetary penalties to the Federal government or any State in cases involving claims related to the provision of health care items and services; and/or
Please see the response to (3) and (4) above.
(6) Suspension or termination of participation in Medicare or Medicaid/TennCare programs;
No.
(7) Is presently subject of/to an investigation, regulatory action, or party in any civil or criminal action of which you are aware;
No.
(8) Is presently subject to a corporate integrity agreement.
No.

Page Eighteen March 26, 2018

- (f) Whether the applicant will participate, within 2 years of implementation of the project, in self-assessment and external assessment against nationally available benchmark data to accurately assess its level of performance in relation to established standards and to implement ways to continuously improve.
- 1. This may include accreditation by any organization approved by Centers for Medicare and Medicaid Services (CMS) and other nationally recognized programs. The Joint Commission or its successor, for example, would be acceptable if applicable.

(p) For Inpatient Psychiatric projects:

- 1. Whether the applicant has demonstrated appropriate accommodations for patients (e.g., for seclusion/restraint of patients who present management problems and children who need quiet space; proper sleeping and bathing arrangements for all patients), adequate staffing (i.e., that each unit will be staffed with at least two direct patient care staff, one of which shall be a nurse, at all times), and how the proposed staffing plan will lead to quality care of the patient population served by the project;
- 2. Whether the applicant has documented its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring systems; and
- 3. Whether an applicant that owns or administers other psychiatric facilities has provided information on satisfactory surveys and quality improvement programs at those facilities.

The applicant verifies and acknowledges that there will be an annual evaluation as to whether the project is providing health care that meets the above quality standards.

27. Project Completion forecast Chart

Please provide a completed Project Completion Forecast Chart.

This is provided on the following page.

PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1. below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

PHASE	DAYS REQUIRED	Anticipated Date (MONTH /YEAR)
1. Initial HSDA Decision Date	0	6-27-18
1. Architectural & engineering contract signed		
2. Construction documents approved by TDH		
3. Construction contract signed		
4. Building permit secured		
5. Site preparation completed		
6. Building construction commenced		
7. Construction 40% complete		
8. Construction 80% complete		
9. Construction 100% complete		
10. * Issuance of license		
11. *Initiation of service	60	8-27-18
12. Final architectural certification of payment	NA	NA
13. Final Project Report Form (HF0055)	120	10-27-18

^{*} For projects that $\underline{DO\ NOT}$ involve construction or renovation: please complete items 11-12 only.

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

Page Nineteen March 26, 2018

28. Proof of Publication

Please submit a copy of the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit which is supplied by the newspaper as proof of the publication of the letter of intent.

Attached after the end of this letter is the full newspaper page in which the notice of intent appeared, as directed.

Additional Information from the Applicant

- A. The applicant found that the patient origin table on page 36 of the application failed to include DeSoto County, Mississippi, which is the second largest contributor of admissions to Crestwyn (but at less than 5% of total admissions). That table, and the narrative on page 34, have been adjusted and the replacement pages 34R and 36R are attached after this page. The change made no significant change in the narrative.
- B. Following the amended patient origin information are additional support letters received from the Mental Health Cooperative, Inc.; Carey Counseling Center; Youthtown Residential Treatment Center; and the Mayor of Germantown.
- C. Attached preceding the new support letters is a revised page 65R, updating information on training rotations at Crestwood in the current year.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please email or telephone me so that we can respond in time to be deemed complete.

Respectfully, Well Com

Jøhn Wellborn Consultant

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map for the Tennessee portion of the service area, using the map on the following page, clearly marked to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the bordering states, if applicable.

Crestwyn's original application in CY2015 projected a regional service area comprised of 68 counties in 3 States--with 86% of its admissions coming from 20 counties (10 Tennessee counties, 4 Mississippi counties, and 6 Arkansas counties).

In its first year of operation, Crestwyn's service area has been extensive. Approximately 95% of its patients came from 63 counties in three States. However, approximately 60% are from Shelby County, and no other Tennessee county contributes more than approximately 3%; most are 1% or less of admissions. Therefore with HSDA staff consent, Shelby County is being declared as the applicant's primary service area ("PSA") with a large number of other counties being included as secondary service area ("SSA") counties. Knox, Davidson, and Rutherford Counties contribute 9-11 annual admissions as well, but they generate less than 1% of admissions and are too distant to be declared within a contiguous secondary service area.

Tab	le A-3A(3)(a): Service Area (West TN and MS/AR)
	Primary Service	Area
	Shelby Count	У
	Secondary Service Are	a Counties
Benton	Dyer	Lake
Benton MS	Fayette	Lauderdale
Carroll	Gibson	Lawrence AR
Chester	Hardeman	Madison
Crittenden AR	Hardin	Marshall MS
Crockett	Haywood	McNairy
Decatur	Henderson	Obion
Desoto MS	Henry	Tipton

Based on first year patient origin at Crestwyn there will also be referrals from counties and States beyond these areas, comprising approximately 13% of admissions. Please see the patient origin table following the service area map.

Table Need3A(3)(b): Patient Origin Data for Crestwyn (2016/2017) Revised 3-20-18							
COUNTY	STATE	Admissions	Cumulative Facility Admissions	County % of All Admissions	Cumulative % of All Admissions		
Shelby	TN	790	790	59.5%	59.5%		
DeSoto	MS	65	855	4.9%	64.4%		
Tipton	TN	41	896	3.1%	67.5%		
Madison	TN	31	927	2.3%	69.8%		
Crittenden	TN	25	952	1.9%	71.7%		
Carroll	TN	22	974	1.7%	73.3%		
Gibson	TN	21	995	1.6%	74.9%		
Lauderdale	TN	21	1,016	1.6%	76.5%		
Marshall	TN	15	1,031	1.1%	77.6%		
Fayette	TN	11	1,042	0.8%	78.5%		
Knox	TN	11	1,053	0.8%	79.3%		
Benton	TN	10	1,063	0.8%	80.0%		
Davidson	TN	10	1,073	0.8%	80.8%		
McNairy	TN	10	1,083	0.8%	81.6%		
Weakley	TN	10	1,093	0.8%	82.3%		
Dyer	TN	9	1,102	0.7%	83.0%		
Hardeman	TN	9	1,111	0.7%	83.7%		
Rutherford	TN	9	1,120				
Henry	TN	8	1,128	0.6%			
Lawrence	TN	8	1,136				
Putnam	TN	8	1,144	0.6%			
Crockett	TN	7	1,151	\$			
Henderson	TN	7	1,158				
Maury	TN	6	1,164				
Montgomery	TN	6	1,170				
Obion	TN	6	1,176				
77 Other <0.5%	TN & Others	152	1,328	11.4%	100.0%		
TOTAL		1,328					

Source: Crestwyn Behavioral Health records.

3.A Discuss the availability of an accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State of Tennessee licensing requirements and/or requirements of accrediting agencies such as the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities.

Crestwyn is an existing provider and is familiar with the requirements of Licensure and the Joint Commission. Crestwyn staffs its units in compliance with those and other professional standards.

This project will not require a large addition of staff; they can be recruited when needed.

B. Verify that the applicant has reviewed and understands all licensing and/or certification as required by the State of Tennessee and/or accrediting agencies such as the Joint Commission for medical/clinical staff. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

The applicant so verifies.

C. Discuss the applicant's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

Crestwyn has a total of nine students from Baptist College of Health Sciences on campus at this time. Clinical rotation agreements are being discussed next year with the following other schools:

Southwest Tennessee Community College
The University of Memphis
Rhodes University
Union University
Christian Brothers University
Northwest Mississippi Community College--DeSoto Campus



275 Cumberland Bond Drive | Nashvilla | Tennastee | 37228 | Phone: 615-726-5240 | 17 haz nihe thlorg

March 21, 2018

Melanie Hill
Executive Director
Tennessee Health Services & Development Agency
Frost building, 3rd Floor
161 Rosa Park Blvd.
Nashville, TN 37243

RE: Crestwyn Behavioral Health

Dear Ms. Hill:

On behalf of the staff of the Mental Health Cooperative, Inc (MHC), I want to express our strong support for the certificate of need application for Crestwyn Behavioral Health.

MHC provides outpatient mental health services for children and adults who are experiencing a serious mental illness. MHC has 10 locations throughout Middle and East Tennessee and we provide services to over 10,000 Consumers. In addition to our outpatient services, MHC is the designated crisis provider for both children and adults in the Nashville area. In our role as a crisis provider, our staff often refer children and youth to Crestwyn for inpatient care and we value the relationship that we have built with Crestwyn admissions staff.

MHC would like to express our support in Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community throughout Tennessee.

Sincerely, Curanda Bractu

Amanda Myatt Bracht, LCSW

Senior Vice President of Clinical Services

Mental Health Cooperative, Inc.

Direct Office Number: 615-744-7442

E-mail: abracht@mhc-tn.org



Carey Counseling Center, Inc.

Supplemental #1

March 27, 2018 11:42 am

408 Virginia Street
P. O. Box 30
Paris, TN 38242
(731) 642-0521
Fax: (731) 642-1010
* 4

Street 1263 Hwy. 45 ByPass N.
30 P. 0. Box 439
1242 Trenton, TN 38382
1521 (731) 855-2871
1-1010 Fax: (731) 855-2877
1-1010 March 21, 2018

19410 W. Main Street P. O. Box 793 Huntingdon, TN 38344 (731) 986-4411 Fax: (731) 986-2678 300 Highway 641 P. O. Box 207 Camden, TN 38320 (731) 584-6999 Fax: (731) 584-3592

1409 N. Morgan Street
P. O. Box 186
Union City, TN 38281
(731) 885-8810
Fax: (731) 885-8588

457 Hannings Lane P. O. Box 648 Martin, TN 38237 (731) 480-0011 Fax: (731) 480-0014 727 Main Street McKenzle, TN 38201 (731) 352-3050 Fax: (731) 352-9304

Ms. Melanie Hill
Executive Director
Tennessee Health Services & Development Agency
Frost Building, 3rd Floor
161 Rosa Park Blvd.
Nashville, TN 37243

RE: Crestwyn Behavioral Health

Dear Ms. Hill:

On behalf of the staff of Carey Counseling Center, Inc. (CAREY), I want to express our strong support for the certificate of need application.

CAREY is a community mental health center serving Northwest TN counties including Benton, Carroll, Gibson, Henry, Lake, Obion and Weakley. We provide outpatient services including TN Healthlink, Medication services and Outpatient therapy along with other grant programs. We also have Residential Programs for the Seriously and Persistently Mentally III (SPMI) population. We provide Mobile Crisis Services to four of our counties, Benton, Carroll, Gibson and Henry.

CAREY would like to express its support in Crestwyn Behavioral Health's request for expansion by way of additional bed space at its facility. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse program throughout West Tennessee. Having additional beds at Crestwyn would be an invaluable resource for our agency and the rest of the mental health and substance abuse community in our area as well.

Cordially,

Robert D. Vaughn Executive Director

Cc: Sean Jones

Director of Crisis Services Carey Counseling Center, Inc.



To Whom It May Concern:

03/10/18

Youth Town of Tennessee is located just south of Jackson, TN and serves adolescents by providing professional residential treatment for co-occurring disorders. I serve as executive director of Youth Town and also continue a part-time private practice, caring for both adults and children 10-15 hours each week.

I am grateful for the fresh, new presence of Crestwyn Behavioral health in the Memphis, TN area. As we are located in the hub of central West Tennessee, I am acutely aware of the need for inpatient psychiatric services and medical detoxification services for adolescents. It is not uncommon, when faced with a referral, to call multiple hospitals only to learn their beds are full. I have been pleased when I have been able to send a referral to Crestwyn and continue to follow the child as he or she continues in residential treatment post-discharge. So, without reservation, I recommend that Crestwyn Behavioral Health be considered for additional beds.

Please feel free to contact me if you have any additional questions.

Faith, Hope and Love,

Pepper Pratt, Ph.D., LPC/MHSP Executive Director Youth Town of Tennessee

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ENNESSEE 1930 South Germantown Road • Germantown, Tennessee 38138-2815 Phone (901) 757-7200 Fax (901) 757-7292 www.germantown-tn.gov

March 19, 2018

Melanie Hill **Executive Director** Tennessee Health Services & Development Agency Frost building, 3rd Floor 161 Rosa Park Blvd. Nashville, TN 37243

RE: Crestwyn Behavioral Health

Dear Ms. Hill:

On behalf of the staff of the City of Germantown, I want to express our strong support for the certificate of need application referenced above. Since opening its doors in 2016, Crestwyn Behavioral Health has been an active community partner and supporter of the mental health and substance abuse programs throughout the city. Having additional beds at Crestwyn would be an invaluable resource for the mental health and substance abuse community and would be a great benefit not only for Shelby County, but surrounding communities as well.

Sincerely,

Mike Palazzolo

Mayor

Office 901-757-7252 Fax 901-757-7292

Mayor@Germantown-TN.gov

AFFIDAVIT

STATE OF TENNESSEE
COUNTY OF DAVIDSON

NAME OF FACILITY: Crestuyn Behavioral Health

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 26th day of witness my hand at office in the County of Davidson, State of Tennessee.

NØTARY PUBLIC

My commission expires July 2.

HF-0043

Revised 7/02

11:42 am

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The forepersons in this County are presently:
Mrs. May Thomas and M. J.P. Vincent County are presently:
Mrs. May Thomas and M. J.P. Vincent County are presently:
Mrs. May Thomas and M. J.P. Vincent County are presently:
Mrs. May Thomas and M. J.P. Vincent County are presently:
Mrs. May Wheeting Room, 201 Poplar Avenue. Memphis, Fornessee 38103.
The grand Jury will nax meet on Tuesday, the 20th day of March, 2018. at 9:00 A.M. in the Grand Jury Meeting Room, 201 Poplar Avenue. Memphis, Fornessee 38103.
The grand Jury when you know the statement to uches on a matter material to the point in question.

Richard L. Desausseure. III Criminal Court Y. Tennessee
AppROVED:
Marcy Ingram Court Statement
County Attorney

Local treasures

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TO APPLY FOR A CERTIFICATE OF NEED NOTIFICATION OF INTENT

and all interested parties, in accordance with T.C.A. Sections 68-11-1601 at seq. and the Ruiss of the Health Services and Development Agency, that Crestwyn Benavioral Health (a behavioral health hospital), owned and managed by Crestwyn Health Group. It (a limited flability company), intends to file an application for a Certificate of Need to to provide official notice to the Health Services and Development Agency

add fourtean (14) licensed beds to its facility at 9485 Crestwyn Hills Cove, Memr TN 38125, at a capital cost estimated at \$100,000.

The facility is licensed for 66 Mental Health Hospital beds by the Department of Mental Health and Substance Abuse Services. These consist of 33 adult psychietric beds, 16 child/adolescent psychiatric beds, and 17 adult dual diagnosis/substance abuse beds. This project proposes to increase total licensed beds to 80 beds. The adult units will be increased to 36 beds (increase of 3). The child/adolescent units will be increased to 32 beds (increase of 16). The dual diagnosis/substance abuse beds in existing semi-private size petient rooms that are currently used as single rooms. The project requires no construction. The project does not contain major medical will be reduced from 17 beds to 12 beds (decrease of 5). All bed increases will be equipment or initiate or discontinue any health service.

Support Group, 4219 Hillsboro Road, Suite 210, Nashville, 1N 37215; (615) 665-2022. Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to the following address: contact person for the project is John Wellborn, who may be reached at Development The anticipated date of fling the application is on or before March 15, 2018.

Tennessee Health Services and Development Agency Health Services and Development Agency

Andrew Jackson Building, 9th Floor 500 Deaderick Street

Nashville, TN 37243

Pursuant to TCA Sec. 68-11-1607(c)(1): (A) any health care institution wishing to oppose a Certificate of Need application must file a written objection with the Health Services and Development Agency no late than filteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is organish scheduled, and (B) any other peason wishing to oppose the application must fille written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

icky finds here

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Official Accreditation Report

Crestwyn Health Group LLC 9485 Crestwyn Hills Memphis, TN 38125

Organization Identification Number: 590562

Initial Unannounced Full Event: 6/27/2016 - 6/29/2016

I ne Joint Commission

Supplemental #1

March 27, 2018 11:42 am

Report Contents

Executive Summary

Survey Analysis for Evaluating Risk (SAFER™)

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right.

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in 60 days. (Please note: If your survey event resulted in a Preliminary Denial of Accreditation status, your timeframe for ESC completion will be 45 days.) The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Plan for Improvement

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

The Joint Commission

Supplemental #1

March 27, 2018 11:42 am

Executive Summary

<u>Program(s)</u> Hospital Accreditation Survey Date(s) 06/27/2016-06/29/2016

Hospital Accreditation:

As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Organization Identification Number: 590562

Page 3 of 19

I ne Joint Commission

SAFER™ Matrix Description

Supplemental #1

March 27, 2018

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:

- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:

- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

All Evidence of Standards Compliance (ESC) forms, which outline corrective actions, will be due in 60 days. For those findings of a higher risk, two additional fields will be required within the ESC for the organization to provide a more detailed description of leadership involvement and preventive analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER Matrix Placement	Required Follow-Up Activity		
LOW/LIMITED	60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections		
MODERATE/LIMITED, LOW/PATTERN, LOW/WIDESPREAD	60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections		
MODERATE/PATTERN, MODERATE/WIDESPREAD	60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections ESC will also include two additional areas surrounding Leadership Involvement and Preventive Analysis Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full triennial survey		
HIGH/LIMITED. HIGH/PATTERN, HIGH/WIDESPREAD	 60 day Evidence of Standards Compliance (ESC) -ESC will include Who, What, When, and How sections ESC will also include two additional areas surrounding Leadership Involvement and Preventive Analysis Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full triennial survey 		

Note: If an Immediate Threat to Health and Safety, also known as Immediate Threat to Life (ITL), is discovered during a survey, the organization immediately receives a preliminary denial of accreditation (PDA) and, within 72 hours, must either entirely eliminate that ITL or implement emergency interventions to abate the risk to patients (with a maximum of 23 days to totally eliminate the ITL). Please see the Accreditation Process Chapter within the Comprehensive Accreditation Manual for more information.

I ne Joint Commission

SAFER Matrix

Supplemental #1

March 27, 2018 11:42 am

Hospital Accreditation Program

	ITL					
Likelihood to Harm a Patient/Visitor/Staff	High	PC.01.02.09 EP 7				
	Moderate	WT.05.01.01 EP 3	EC.02.04.03 EP 1 PC.01.02.13 EP 6 RC.02.04.01 EP 3	PC.01.02.13 EP 2 PC.01.03.01 EP 1		
Likelii	Low	LS.02.01.20 EP 26 MM.04.01.01 EP 9 PC.01.02.01 EP 23	MS.06.01.05 EP 7 PC.01.03.01 EP 5 RC.02.03.07 EP 4			
		Limited	Pattern Scope	Widespread		

Supplemental #1

March 27, 2018

Requirements for Improvement - Summary 42 am

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in 60 days. (Please note: If your survey event resulted in a Preliminary Denial of Accreditation status, your timeframe for ESC completion will be 45 days.) The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Summary of CMS Findings

Supplemental #1

March 27, 2018

CoP:

§482.24

Tag: A-0431

Deficiency: Standard 42 am

Corresponds to: HAP

Text:

§482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(2)	A-0450	HAP - RC.02.03.07/EP4	Standard

CoP:

§482.41

Tag: A-0700

Deficiency: Standard

Corresponds to: HAP

Text:

§482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(c)(2)	A-0724	HAP - EC.02.04.03/EP1	Standard
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.20/EP26	Standard

CoP:

§482.61

Tag: B103

Deficiency: Standard

Corresponds to: HAP

Text:

§482.61 Condition of Participation: Special medical record requirements for psychiatric

hospitals.

The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.

CoP Standard	Tag	Corresponds to	Deficiency
§482.61(e)	B133	HAP - RC.02.04.01/EP3	Standard
§482.61(a)(5)	B109	HAP - PC.01.02.13/EP6	Standard
§482.61(b)(7)	B117	HAP - PC.01.02.13/EP2	Standard
§482.61(c)(1)	B119	HAP - PC.01.03.01/EP1	Standard
§482.61(c)(1)(ii)	B121	HAP - PC.01.03.01/EP5	Standard

CoP:

§482.22

Tag: A-0338

Deficiency: Standard

Corresponds to: HAP

Text:

§482.22 Condition of Participation: Medical staff

The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital.

Summary of CMS Findings

Supplemental #1

CoP Standard	Tag	Corresponds to	March 27, 2018 11:42 Deficiency
§482.22(a)(1)	A-0340	HAP - MS.06.01.05/EP7	Standard

Supplemental #1

March 27, 2018

Requirements for Improvement - Detait42 am

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.02.04.03

Standard Text:

The hospital inspects, tests, and maintains medical equipment.

Element(s) of Performance:

1. For hospitals that do not use Joint Commission accreditation for deemed status purposes: Before initial use of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. (See also EC.02.04.01, EP 2)

For hospitals that use Joint Commission accreditation for deemed status purposes: Before initial use and after major repairs or upgrades of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. (See also EC.02.04.01, EP 2)

Likelihood to Cause Harm:

Moderate

Scope:

Pattern

Observation(s):

EP 1

§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

This Standard is NOT MET as evidenced by:

Observed in Document Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

During the document review and staff interview it was observed that the hospital did not perform safety, operational and functional checks before initial use for all of the hospital's medical equipment listed on the medical equipment inventory list. It was observed that the hospital started receiving their patients on May 2, 2016 and the documentation verified that the initial inspections of the medical equipment which includes but not limited to 3 AED devices were not conducted until June 2, 2016.

Chapter:

Life Safety

Program:

Hospital Accreditation

Standard:

LS.02.01.20

Standard Text:

The hospital maintains the integrity of the means of egress.

Supplemental #1

March 27, 2018 11:42 am

Element(s) of Performance:

26. In new buildings, no dead-end corridor is longer than 30 feet. (For full text and any exceptions, refer to NFPA 101-2000: 18.2.5.10)

Note: Existing dead-end corridors are permitted to be used if it is impractical and unfeasible to alter them. (For full text and any exceptions, refer to NFPA 101-2000: 19.2.5.10)

Likelihood to Cause Harm:

Low

Scope:

Limited

Observation(s):

EP 26

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

During the building tour it was observed that the corridor near the dietary department and hazardous area room 1154 had a dead end corridor that was greater than 30 feet.

Chapter:

Medical Staff

Program:

Hospital Accreditation

Standard:

MS.06.01.05

Standard Text:

The decision to grant or deny a privilege(s), and/or to renew an existing privilege

(s), is an objective, evidence-based process.

Element(s) of Performance:

7. The hospital queries the National Practitioner Data Bank (NPDB) when clinical privileges are initially granted, at the time of renewal of privileges, and when a new privilege(s) is requested.

Likelihood to Cause Harm:

Low

Scope:

Pattern

Supplemental #1

Observation(s):

March 27, 2018 11:42 am

EP 7

§482.22(a)(1) - (A-0340) - (1) The medical staff must periodically conduct appraisals of its members. This Standard is NOT MET as evidenced by:

Observed in Credentialing and Privileging at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 2 of 3 medical staff/credentialing files reviewed, Radiologist chart's had the NPDB queried in 2014, but not before starting work for the hospital in May 2016

Chapter:

Medication Management

Program:

Hospital Accreditation

Standard:

MM.04.01.01

Standard Text:

Medication orders are clear and accurate.

Element(s) of Performance:

9. A diagnosis, condition, or indication for use exists for each medication ordered.

Note: This information can be anywhere in the medical record and need not be on the order itself. For example, it might be part of the medical history.

Likelihood to Cause Harm:

Scope:

Limited

Observation(s):

EP9

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. One record had multiple medications that did not have indications. The medications were Depakote and Geodon. The MD note did not explain the use of the medications.

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.01.02.01

Supplemental #1

March 27, 2018

Standard Text:

The hospital assesses and reassesses its patients. 11:42 am

Element(s) of Performance:

23. During patient assessments and reassessments, the hospital gathers the data and information it requires. (See also PC.01.01, EP 24)

Likelihood to Cause Harm:

Low

Scope:

Limited

Observation(s):

EP 23

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. One patient who scored low fall risk was not rescreened in one week according to directions on the form. However, the policy for fall risk does not address reassessments.

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. While the CAGE assessment had been done, the actual alcohol assessment had not been done. The patient was admitted 6/21/16 and the assessment should be done within 72 hours according to hospital policy.

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. In 1 of 10 patient records reviewed, of both open and closed medical records the section of the medical history and physical exam that addressed previous surgical procedures was left blank. It is likely that the patient, an adolescent, had not had any procedures in the past, however, that should have been indicated in the medical history and physical examination.

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.01.02.09

Standard Text:

The hospital assesses the patient who may be a victim of possible abuse and

neglect.

Element(s) of Performance:

7. The hospital reports cases of possible abuse and neglect to external agencies, in accordance with law and regulation. (See also RI.01.06.03, EP 3)

Likelihood to Cause Harm:

High

Scope:

Limited

Observation(s):

Supplemental #1

March 27, 2018

EP 7

11:42 am

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. In 1 of 1 patient records reviewed, closed medical record of a 17 year old adolescent who had been admitted for severe depression and melancholy in part related to her first sexual encounter which she related to care givers upon admission. The encounter had occurred, ostensibly, with a 25 year old man. There was no discussion in the medical record that the sexual molestation had been reported to the Division of Child Protective Services.

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.01.02.13

Standard Text:

The hospital assesses the needs of patients who receive treatment for emotional

and behavioral disorders.

Element(s) of Performance:

- 2. Patients who receive treatment for emotional and behavioral disorders receive an assessment that includes the following:
- Current mental, emotional, and behavioral functioning
- Maladaptive or other behaviors that create a risk to the patient or others
- Mental status examination
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Reason for admission as stated by the patient and/or others significantly involved in the patient's care
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Onset of the patient's illness and circumstances leading to admission
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Inventory of the patient's strengths and disabilities (such as psychiatric, biopsychosocial problems requiring treatment/intervention) written in a descriptive manner on which to base a treatment plan (See also PC.01.03.01, EP 1)

Likelihood to Cause Harm: Moderate Scope: WideSpread

Supplemental #1

March 27, 2018 11:42 am

6. Based on the patient's age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following:

- A psychiatric evaluation
- Psychological assessments, including intellectual, projective, neuropsychological, and personality testing
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Complete neurological examination at the time of the admission physical examination, when indicated (For more information on physical examination, see PC.01.02.03, EP 4)

Likelihood to Cause Harm: Moderate Scope: Pattern

Observation(s):

EP 2

§482.61(b)(7) - (B117) - (7) Include an inventory of the patient's assets in descriptive, not interpretative, fashion. This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 9 of 10 patient records reviewed, Both open and closed medical records reviewed the inventory of assets checked in the psychlatric evaluation did not give sufficient detail to determine how they should be used in treatment of the patient. The recreation therapist did detail activity preferences including games, television programs, sports in the activities interventions of the plan. However, these don't demonstrate the personal strengths as defined in the interpretive guidelines of conditions of participation: "...although the term strength is often used interchangeably with assets, only the assets which describe personal strengths on which to base the treatment plan or which are useful in therapy represent personal strengths. Strengths are personal attributes i.e. knowledge, skills, aptitudes, personal experiences, education, talents and employment status which may be useful in developing a meaningful treatment plan..."

EP 6

 $\S482.61(a)(5)$ - (B109) - (5) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.

This Standard is NOT MET as evidenced by:

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 1 of 10 patient records reviewed, One of the 10 open and closed medical records reviewed had an incomplete neurological exam. The cranial nerve evaluation was not completed.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.03.01

Supplemental #1

March 27, 2018

Standard Text:

The hospital plans the patient's care.

11:42 am

Element(s) of Performance:

1. The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. (See also RC.02.01.01, EP 2; PC.01.02.13, EP 2)

Likelihood to Cause Harm:

Moderate

Scope:

WideSpread

5. The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals. Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The patient's goals include both short- and long-term goals.

Likelihood to Cause Harm:

Low

Scope:

Pattern

Observation(s):

EP 1

§482.61(c)(1) - (B119) - (1) Each patient must have an individual comprehensive treatment plan that must be based on an inventory of the patient's strengths and disabilities.

The written plan must include—

This Standard is NOT MET as evidenced by:

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 9 of 10 patient records reviewed, Both open and closed it was evident that the treatment plan was not based on the inventory of the patient's strengths and disabilities. The selection of strengths and disabilities that is attached to the Master Treatment Plan is a check list and not further referenced in the goals established in the treatment plan. It also does not correlate with the inventory of strengths and disabilities of the checklist in the psychiatric evaluation. General statements such as "hobbies", "motivation", "talents" etc. should be followed with further detail of what each of those selections reference. Of note; the activities therapists do lists "likes" and "dislikes" in the treatment plans that include specific sports, activities, television etc.

EP 5

§482.61(c)(1)(ii) - (B121) - (ii) Short-term and long-range goals; This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 3 of 6 patient records reviewed, There were goals that were not measurable. Examples include: "David will process life stressors contributing to depression." and "Pt will have alternative coping strategies that reinforce positive outcomes." "will be compliant with detox protocol."

Supplemental #1

March 27, 2018

11:42 am

Chapter:

Record of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

RC.02.03.07

Standard Text:

Qualified staff receive and record verbal orders.

Element(s) of Performance:

4. Verbal orders are authenticated within the time frame specified by law and regulation.

Likelihood to Cause Harm:

Low

Scope:

Pattern

Observation(s):

FP 4

§482.24(c)(2) - (A-0450) - (2) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 2 of 7 patient records reviewed, Verbal orders had not been signed within the 48 hours which was the hospital's policy. One telephone order contained 5 different medications and was given on 5/11/16 and was signed on 5/14/16. Another medication had been given on 6/23/15 and had not been signed by 6/27/16 during the survey.

Chapter:

Record of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

RC.02.04.01

Standard Text:

The hospital documents the patient's discharge information.

Element(s) of Performance:

Supplemental #1

March 27, 2018 11:42 am

3. In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the following:

- The reason for hospitalization
- The procedures performed
- The care, treatment, and services provided
- The patient's condition and disposition at discharge
- Information provided to the patient and family
- Provisions for follow-up care

Note 1: A discharge summary is not required when a patient is seen for minor problems or interventions, as defined by the medical staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care.

Note 2: When a patient is transferred to a different level of care within the hospital, and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used.

Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The record of each patient discharged needs to include a discharge summary with the above information. The exceptions in Notes 1 and 2 are not applicable. All patients discharged need to have a discharge summary.

Likelihood to Cause Harm:

Moderate

Scope:

Pattern

Observation(s):

EP3

§482.61(e) - (B133) - §482.61(e) Standard: Discharge planning and discharge summary.

The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the patient's hospitalization and

This Standard is NOT MET as evidenced by:

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site for the Psychiatric Hospital deemed service.

In 3 of 3 patient records reviewed, All closed medical records that had a discharge summary and "Discharge Plan" there was a recapitulation of the patient's hospital course, however, none of the three contained a detail of the goals and specifically goal attainment.

Chapter:

Waived Testing

Program:

Hospital Accreditation

Standard:

WT.05.01.01

Standard Text:

The hospital maintains records for waived testing.

Supplemental #1

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Element(s) of Performance:

3. Quantitative test result reports in the medical record for waived testing are accompanied by reference intervals (normal values) specific to the test method used and the population served. Note 1: Semiquantitative results, such as urine macroscopic and urine dipsticks, are not required to comply with this element of performance.

Note 2: If the reference intervals (normal values) are not documented on the same page as and adjacent to the waived test result, they must be located elsewhere within the permanent medical record. The result must have a notation directing the reader to the location of the reference intervals (normal values) in the medical record.

Likelihood to Cause Harm:

Moderate

Scope:

Limited

Observation(s):

EP3

Observed in Record Review at Crestwyn Health Group (9485 Crestwyn Hills, Memphis, TN) site. In 1 of 1 patient records reviewed, Closed medical record of a very brittle diabetic patient it was noted that the reference ranges for the device used for point of care testing for blood glucose was not in the patient's medical record.

Supplemental #1

March 27, 2018

Plan for Improvement - Summary 1:42 am

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Number of PFIs:

0

March 27, 2018 11:42 am

The Commercial Appeal Affidavit of Publication

STATE OF TENNESSEE COUNTY OF SHELBY

Personally appeared before me, Glenn W. Edwards, a Notary Public, Helen Curl, of MEMPHIS PUBLISHING COMPANY, a corporation, publishers of The Commercial Appeal, morning and Sunday paper, published in Memphis, Tennessee, who makes oath in due form of law, that she is Legal Clerk of the said Memphis Publishing Company, and that the accompanying and hereto attached advertisement was published in the following editions of The Commercial Appeal, to-wit:

March 10, 2018

Subscribed and sworn to before me this 12th day of March, 201

My commission expires January 20, 2020 My Or



Official Accreditation Report

DMC - Memphis, Inc. 3000 Getwell Road Memphis, TN 38118

Organization Identification Number: 7875

Unannounced Full Event: 12/1/2015 - 12/3/2015

Supplemental #1
March 27, 2018
11:42 am

Report Contents

Executive Summary

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Opportunities for Improvement

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Plan for Improvement

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Supplemental #1
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11:42 am

Executive Summary

Program(s)
Hospital Accreditation

Survey Date(s) 12/01/2015-12/03/2015

Behavioral Health Care Accreditation

Hospital Accreditation:

As a result of the accreditation activity conducted on the above date(s), you have met the criteria for Accreditation with Follow-up Survey.

If your organization wishes to clarify any of the standards you believe were compliant at the time of survey, you may submit clarifying Evidence of Standards Compliance in 10 business days from the day this report is posted to your organization's extranet site.

You will have follow-up in the area(s) indicated below:

- As a result of a Condition Level Deficiency, an Unannounced Medicare
 Deficiency Follow-up Survey will occur. Please address and correct any
 Condition Level Deficiencies immediately, as the follow-up event addressing
 these deficiencies will occur within 45 days of the last survey date identified
 above. The follow-up event is in addition to the written Evidence of
 Standards Compliance response.
- Evidence of Standards Compliance (ESC)

Behavioral Health Care Accreditation:

As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Organization Identification Number: 7875

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Requirements for Improvement - Summary

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site:

Program
Standards: EC.02.05.01 EP15
EC.02.05.09 EP1,EP3
LS.02.01.20 EP1,EP13,EP31
LS.02.01.34 EP2
MS.03.01.01 EP2
PC.01.02.08 EP1
PC.02.01.11 EP2

PC.02.01.11 EP2 PC.04.01.05 EP8

Hospital Accreditation

Program:

Program: Behavioral Health

Care Accreditation Program

Piograffi

Standards: CTS.04.03.33 EP3

NPSG.15.01.01 EP1

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

Program: Hospital Accreditation

Program

Standards: EC.02.02.01 EP5

EC.02.05.05 EP5

EC.02.06.01 EP1,EP13

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Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

survey report	was originally posted	to your organization's extranet site.
	HR.01.02.05	EP1
	IC.02.01.01	EP1
	LD.01.03.01	EP2
	LS.02.01.10	EP3,EP5,EP9
	LS.02.01.30	EP11
	LS.02.01.35	EP5
	MM.03.01.01	EP2
	MS.01.01.01	EP3,EP16
	MS.08.01.03	EP2
	PC.01.02.13	EP2
	PI.02.01.01	EP4
	RC.01.01.01	EP19
Program:	Behavioral Health Care Accreditation Program	
Standards:	CTS.02.01.11	EP1
	CTS.03.01.01	EP1
	CTS.03.01.03	EP3

The Joint Commission Summary of CMS Findings

Supplemental #1 March 27, 2018

11:42 am

CoP:

§482.11

Tag: A-0020

Deficiency: Standard

Corresponds to: HAP

Text:

§482.11 Condition of Participation: Compliance with Federal, State and Local Laws

CoP Standard	Tag	Corresponds to	Deficiency
§482.11(c)	A-0023	HAP - HR.01.02.05/EP1	Standard

CoP:

§482.24

Tag: A-0431

Deficiency: Standard

Corresponds to: HAP

Text:

§482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Standard

CoP:

§482.41

Tag: A-0700

Deficiency: Condition

Corresponds to: HAP

Text:

§482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(a)	A-0701	HAP - EC.02.02.01/EP5, EC.02.06.01/EP1	Standard
§482.41(b)(5)	A-0712	HAP - LS.02.01.30/EP11	Standard
§482.41(c)(2)	A-0724	HAP - EC.02.05.09/EP1, EP3	Standard
§482.41(c)(4)	A-0726	HAP - EC.02.06.01/EP13	Standard
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.10/EP3, EP5, EP9, LS.02.01.20/EP1, EP13, EP31, LS.02.01.30/EP11, LS.02.01.34/EP2, LS.02.01.35/EP5	Standard

CoP:

§482.42

Tag: A-0747

Deficiency: Standard

Corresponds to: HAP - IC.02.01.01/EP1,

EC.02.05.01/EP15

The Joint Commission Summary of CMS Findings

Supplemental #1 March 27, 2018 11:42 am

Text:

§482.42 Condition of Participation: Infection Control

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

CoP:

§482.21

Tag: A-0263

Deficiency: Standard

Corresponds to: HAP - PI.02.01.01/EP4

Text:

§482.21 Condition of Participation: Quality Assessment and Performance Improvement

Program

The hospital must develop, implement, and maintain an effective, ongoing, hospitalwide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI

program for review by CMS.

CoP:

§482.12

Tag: A-0043

Deficiency: Condition

Corresponds to: HAP - LD.01.03.01/EP2

Text:

§482.12 Condition of Participation: Governing Body

There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.

CoP Standard	Tag	Corresponds to	Deficiency
§482.12(a)(4)	A-0048	HAP - MS.01.01.01/EP3	Standard

CoP:

§482.22

Tag: A-0338

Deficiency: Standard

Corresponds to: HAP

Text:

§482.22 Condition of Participation: Medical staff

The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.22(a)(1)	A-0340	HAP - MS.03.01.01/EP2, MS.08.01.03/EP2	Standard
§482.22(c)(5)(i)	A-0358	HAP - MS.01.01.01/EP16	Standard

Requirements for Improvement - Detail

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

Standard Text:

EC.02.02.01

The hospital manages risks related to hazardous materials and waste.

Element(s) of Performance:

5. The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals.



Scoring Category: C

Score:

Partial Compliance

Observation(s):

EP 5

§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed in the Surgery decontamination room that the eyewash station that was an unapproved two step unit that required turning on the faucet and then pressing a bypass valve on the spout to initiate water flow. The unit was require due to the use of Prolystica and Surgistain which both required a 15 minute flush in the SDS information. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed in the old ICU dialysis area on the 2nd floor that there was no eyewash station. The unit was require due to the use liquid chlorine bleach which required a 15 minute flush in the SDS information. This was verified by the Director of Plant Operations.

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.02.05.01

Standard Text:

The hospital manages risks associated with its utility systems.

Supplemental #1 March 27, 2018

Element(s) of Performance:

15. In areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, and filtration efficiencies. (See also EC.02.06.01, EP 13)

Note: Areas designed for control of airborne contaminants include spaces such as operating rooms, special procedure rooms, delivery rooms for patients diagnosed with or suspected of having airborne communicable diseases (for example, pulmonary or laryngeal tuberculosis), patients in 'protective environment' rooms (for example, those receiving bone marrow transplants), laboratories, pharmacies, and sterile supply rooms. For further information, see Guidelines for Design and Construction of Health Care Facilities, 2010 edition, administered by the Facility Guidelines Institute and published by the American Society for Healthcare Engineering (ASHE).

Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP 15

§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control This Standard is NOT MET as evidenced by:

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that in the Surgery area that the clean sterile room was negative to the decontamination room. This was identified on a Test and Balance report on 5/11/15 and not corrected. This was verified by the Director of Plant Operations. This was corrected during the survey by tightening the belt on the supply unit and verifying the proper test & balance.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that in the Surgery area that the clean storage room was negative to the corridor. This was identified on a Test and Balance report on 5/11/15 and not corrected. This was verified by the Director of Plant Operations. This was corrected during the survey by tightening up the belt on the supply unit and verified by test & balance.

Observed In Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that in the Surgery area that the sub-sterile room between OR #3 & OR #4 was positive to both OR's. This was verified by the Director of Plant Operations. This was corrected during the survey by tightening up the belt on the exhaust fan and verifying the test & balance.

11:42 am

Supplemental #1
March 27, 2018
11:42 am

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.02.05.05

ESC 80

Standard Text:

The hospital inspects, tests, and maintains utility systems.

Note: At times, maintenance is performed by an external service. In these cases, hospitals are not required to possess maintenance documentation but must have

access to such documentation during survey and as needed.

Element(s) of Performance:

5. The hospital inspects, tests, and maintains the following: Non-high-risk utility system components on the inventory. These activities are documented. (See also EC.02.05.01, EPs 2 and 4)



Scoring Category: C

Score:

Partial Compliance

Observation(s):

EP 5

Observed in Individual Tracer at DMC - Memphis, Inc. I 3000 Getwell Road, Memphis, TN (Main) (3000 Getwell Road, Memphis, TN) site.

Observed in Document Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. It was observed that smoke and fire testing was done on 9/25/15 and that no repairs to falled dampers had been done as of 12/2/15. This was verified by the Director of Plant Operations.

Observed in Document Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. It was observed that smoke and fire testing was done on 9/25/15 and that no repairs to failed dampers had been done as of 12/2/15. This was verified by the Director of Plant Operations.

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.02.05.09

Standard Text:

ESC 45 days

The hospital inspects, tests, and maintains medical gas and vacuum systems.

Note: This standard does not require hospitals to have the medical gas and vacuum systems discussed below. However, if a hospital has these types of systems, then

the following inspection, testing, and maintenance requirements apply.

Supplemental #1

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Element(s) of Performance:

1. In time frames defined by the hospital, the hospital inspects, tests, and maintains critical components of piped medical gas systems, including master signal panels, area alarms, automatic pressure switches, shutoff valves, flexible connectors, and outlets. These activities are documented. (See also EC.02.05.01, EP 3)



Scoring Category: A

Score:

Insufficient Compliance

The hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control.



Scoring Category : A

Score:

Insufficient Compliance

Observation(s):

EP 1

§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

This Standard is NOT MET as evidenced by:

Observed in Document Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that in the Medical Gas testing report dated 10/23/15 that PACU had no alarm panel or vacuum zone valve and that Surgery had no functioning alarm lights for medical air and vacuum. Surgery also had no audible alarm sounds for any gases. In review of the testing report from 10/24/14 that the same deficiencies had been identified and that a proposal had been given for their repair. There had been no repairs to these deficiencies since 2014. This was verified by the Director of Plant Operations.

EP3

§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

During tour of the surgical suite, it was noted that storage carts and shelving located along wall in the main corridor of the operating room were blocking access to the medical gas shutoff valves located behind them.

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.02.06.01



Supplemental #1

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Standard Text:

The hospital establishes and maintains a safe, functional environment.

Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services

appropriate to the needs of the community.

Element(s) of Performance:

1. Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.



Scoring Category: C

Score:

Insufficient Compliance

13. The hospital maintains ventilation, temperature, and humidity levels suitable for the care, treatment, and services provided. (See also EC.02.05.01, EP 15)



Scoring Category : A

Score:

Insufficient Compliance

Observation(s):

Supplemental #1
March 27, 2018
11:42 am

EP 1 §482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.

This Standard is NOT MET as evidenced by:

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Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

During tour of the surgical suite and evaluation of the process for decontamination of GI endoscopes, it was noted that the storage cabinet for the clean endoscopes was blocking access to an electrical panel in the operating room.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed in Operating room #1 that the electrical panel was blocked by a C-arm and other equipment. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed in Operating room #2 that the electrical panel was locked and OR staff did not have a key to access to be able to reset a circuit breaker. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that in the Operating Room #1 that there were 2 blue multi outlet power taps that were daisy chained with a white multi power tap that was installed on an anesthesia machine. One of the units was clamped to the anesthesia machine and another to a roll around pole with a bair hugger plugged into it which pulled 9.5 amps. The units are UL1363A and rated at 15 amps. The units had multiple other pieces of equipment plugged into them and open available outlets that could used to plug in other devices. They were not part of a tested assembly.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that in the Operating Room #2 that there was a blue multi outlet power tap that was clamped to a roll around pole with a bair hugger plugged into it which pulled 9.5 amps. The unit is UL1363A and rated at 15 amps. The unit had multiple other pieces of equipment plugged into it and open available outlets that could used to plug in other devices. It was not part of a tested assembly.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that in the Operating Room #3 that there was a blue multi outlet power tap that was clamped to a roll around pole with a bair hugger plugged into it which pulled 9.5 amps. The unit is UL1363A and rated at 15 amps. The unit had multiple other pieces of equipment plugged into it and open available outlets that could used to plug in other devices. It was not part of a tested assembly.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that in the Operating Room #1 that there were twist lock to standard pronged plug extension cord adapters that were used to power equipment that were not on the Biomedical equipment list as tested assemblies. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that in the Operating Room #3 that there were twist lock to standard pronged plug extension cord adapters that were used to power equipment that were not on the Biomedical equipment list as tested assemblies. This was verified by the Director of Plant Operations.

EP 13

\$482.41(c)(4) - (A-0726) - (4) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.

This Standard is NOT MET as evidenced by:

Supplemental #1

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Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that on the 4th floor nursing unit that the clean utility room was negative to the corridor. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that on the 4th floor nursing unit that the clean linen room was negative to the corridor. This was verified by the Director of Plant Operations

Observed in Bullding Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that on the 2nd floor medical/surgical unit that the clean supply room was negative to the corridor. This was verified by the Director of Plant Operations

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed on the 2-West Psych unit that the solled utility room was positive to the corridor when it should have been negative. This was verified by the Director of Plant Operations.

Chapter:

Human Resources

Program:

Hospital Accreditation

Standard:

HR.01.02.05

Standard Text:

The hospital verifies staff qualifications.

Supplemental #1
March 27, 2018

March 27, 2018 11:42 am

Element(s) of Performance:

1. When law or regulation requires care providers to be currently licensed, certified, or registered to practice their professions, the hospital both verifies these credentials with the primary source and documents this verification when a provider is hired and when his or her credentials are renewed. (See also HR.01.02.07, EP 2)

Note 1: It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented.

Note 2: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source.

Note 3: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary.

Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP 1

§482.11(c) - (A-0023) - (c) The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws.

This Standard is NOT MET as evidenced by:

Observed in Competency Session at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

There was a lack of documentation to demonstrate verification of the dietician's license with the primary source at the time of license renewal. The dietician's license expired 9/30/2014 but was verified with the primary source 8/18/2015. (Note: There was no lapse in licensure.)

Chapter:

Infection Prevention and Control

Program:

Hospital Accreditation

Standard:

IC.02.01.01

Standard Text:

The hospital implements its infection prevention and control plan.



Supplemental #2

March 27, 2018 10:19 am

Element(s) of Performance:

1. The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.



Scoring Category: C

Score:

Partial Compliance

Observation(s):

EP 1

§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control

This Standard is NOT MET as evidenced by:

Observed in Tracer Activities at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

Dual diagnosis unit: The shower curtain in a patient's bathroom was visibly contaminated with black mold.

Observed in Tracer Activities at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

Mental health unit 1: A 2nd shower curtain in a patient's bathroom was visibly contaminated with black mold.

Chapter:

Leadership

Program:

Hospital Accreditation

Standard:

LD.01.03.01

ESC 60 days

Standard Text:

The governing body is ultimately accountable for the safety and quality of care,

treatment, and services.

Element(s) of Performance:

The governing body provides for organization management and planning.



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP 2

§482.12 - (A-0043) - §482.12 Condition of Participation: Condition of Participation: Governing Body This Condition is NOT MET as evidenced by:

Observed In Auto Score for CLD at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. The governing body/leadership did not ensure that the following Conditions of Participation were met as determined through observations, documentation, and staff interviews:§482.41 - (A-0700), §482.12 - (A-0043)

Supplemental #1

March 27, 2018 12:06 pm

Chapter:

Life Safety

Program:

Hospital Accreditation

Standard:

LS.02.01.10

ESC 60 days

Standard Text:

Building and fire protection features are designed and maintained to minimize the

effects of fire, smoke, and heat.

Element(s) of Performance:

3. Walls that are fire rated for 2 hours (such as common walls between buildings and occupancy separation walls within buildings) extend from the floor slab to the floor or roof slab above and extend from exterior wall to exterior wall. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.2.2)



Scoring Category: A

Score:

Insufficient Compliance

5. Doors required to be fire rated have functioning hardware, including positive latching devices and self-closing or automatic-closing devices. Gaps between meeting edges of door pairs are no more than 1/8 inch wide, and undercuts are no larger than 3/4 inch. (See also LS.02.01.30, EP 2; LS.02.01.34, EP 2) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1, 8.2.3.2.1 and NFPA 80-1999: 2-4.4.3, 2-3.1.7, and 1 -11.4)



Scoring Category: C

Score:

Insufficient Compliance

9. The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes that penetrate fire-rated walls and floors are protected with an approved fire-rated material.

Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.4.2)



Scoring Category: C

Score:

Partial Compliance

Observation(s):

Supplemental #1 March 27, 2018 11:41 A.M.

EP3

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed on the 4th floor nursing unit that the 1 hour smoke/fire wall was not sealed properly to the deck above patient room #413. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed on the 4th floor nursing unit that the 1 hour smoke/fire wall was not sealed properly to the deck above patient room #418. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that at the old ICU - Dialysis unit that above the 11/2 hour fire doors that the 2 hour fire wall was not sealed to the deck. This was verified by the Director of Plant Operations.

EP 5

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Supplemental #1 March 27, 2018

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed on the 2nd floor near the old ICU dialysis unit that the cross corridor fire doors in the two hour fire wall did not latch when allowed to close due to a faulty coordinator. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that at the old ICU - Dialysis unit that the 11/2 hour fire doors in the 2 hour fire wall had the latching hardware removed and were being held shut with a magnetic lock system. It was evident by the plates on the door where the hardware used to be. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that at the old ICU - Dialysis unit that the 11/2 hour fire doors in the 2 hour fire wall had the latching hardware removed and were being held shut with a magnetic lock system. It was evident by the plates on the door where the hardware used to be. This was verified by the Director of Plant Operations.

EP9

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed on the 2nd floor medical/surgical unit that the 1 hour smoke/fire wall was had 3 medical gas pipes that were not sealed properly above patient room #267. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed on the 2nd floor medical/surgical unit that the 1 hour smoke/fire wall was had a 1/2 inch and a 3/4 inch conduit that had open ends that were not sealed properly above patient room #267. This was verified by the Director of Plant Operations

Chapter:

Life Safety

Program:

Hospital Accreditation

Standard:

LS.02.01.20

ESC 45 days

Standard Text:

The hospital maintains the integrity of the means of egress.

Element(s) of Performance:

1. Doors in a means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.2.2.4)

1

Scoring Category: A

Score:

Insufficient Compliance

13. Exits, exit accesses, and exit discharges are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text and any exceptions, refer to NFPA 101-2000: 7.1.10.1)



Scoring Category: C

Score:

Insufficient Compliance

31. Exit signs are visible when the path to the exit is not readily apparent. Signs are adequately lit and have letters that are 4 or more inches high (or 6 inches high if externally lit). (For full text and any exceptions, refer to NFPA 101-2000: 7.10.1.2, 7.10.5, 7.10.6.1, and 7.10.7.1)



Scoring Category: C

Score:

Partial Compliance

Observation(s):

Supplemental #1
March 27, 2018
11:42 am

EP 1

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/fbr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Bullding Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that the Surgery main entrance cross corridor doors had a slide bolt on one door and a padlock on the other door that were locked at night to secure the area. This made egress through these doors impossible even though they were a marked exit path. The locks were removed during the survey.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that at the marked exit doors leading out of the 2nd floor old ICU dialysis unit that they were magnetic locked and did not release when traveling in the egress direction unless you pushed an exit button located 9 feet away from the doors. There was no proximity sensor that allowed you to egress. They were connected to the fire alarm system and would release on fire alarm. This was verified by the Director of Plant Operations.

EP 13

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/fbr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Supplemental #1

March 27, 2018 11:42 am

Observed in Building Tour at DMC - Memphis, inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed in the Surgery area exit corridor that was unsprinkled that there was a linen cart and a storage shelf that impaired the 8 foot hall width and impeded exiting. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed in the Surgery area exit corridor that was unsprinkled that there was a microscope and a Stryker supply cart that impaired the 8 foot hall width and impeded exiting. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed in the Surgery area exit corridor that was unsprinkled that there was a supply cart, two multi-drawer cabinets and an H tank on wheels that impaired the 8 foot hall width and impeded exiting. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed on the 2nd floor medical/surgical unit that the exit corridor had a computer on wheels that was plugged in, two blood pressure machines and two linen carts located in the hall near patients rooms 257 and 263 that impaired the 8 foot hall width and impeded exiting. This was verified by the Director of Plant Operations.

EP 31

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed on the 2nd floor Geri Psych unit that the day room needed an exit sign over the second exit door. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed on the 2-West Psych unit that there were four (4) exit signs needed over the control doors in the corridor to identify the exit path. This was verified by the Director of Plant Operations.

Chapter:	Life Safety

Supplemental #1

March 27, 2018 11:42 am

Program:

Hospital Accreditation

Standard:

LS.02.01.30

Standard Text:

The hospital provides and maintains building features to protect individuals from the

hazards of fire and smoke.

Element(s) of Performance:

11. Corridor doors are fitted with positive latching hardware, are arranged to restrict the movement of smoke, and are hinged so that they swing. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 1 inch. Roller latches are not acceptable. Note: For existing doors, it is acceptable to use a device that keeps the door closed when a force of 5 foot-pounds are applied to the edge of the door. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.6.3.2, 18/19.3.6.3.1, and 7.2.1.4.1)



Scoring Category: C

Score:

Partial Compliance

Observation(s):

EP 11

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

§482.41(b)(5) - (A-0712) - (5) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to hospitals.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that the door to the Surgery decontamination room that opened to the exit corridor did not latch and was equipped with a door closer. This was verified by the Director of Plant Operations.

Observed in Building Tour at DMC - Memphis, Inc. I 3000 Getwell Road, Memphis, TN (Main) (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed in the Surgery area that the unsprinkled corridor door to Pre-op holding removed and had been fitted with a self closer and door latch. The door on to PACU on the opposite side of the hall still retained its door with self closer and door latch. This was verified by the Director of Plant Operations.

Chapter:

Life Safety

Program:

Hospital Accreditation

Standard:

LS.02.01.34



11:42 am

Standard Text:

The hospital provides and maintains fire alarm systems.

Element(s) of Performance:

2. The master fire alarm control panel is located in a protected environment (an area enclosed with 1-hour fire-rated walls and 3/4-hour fire-rated doors) that is continuously occupied or in an area with a smoke detector. (See also LS.02.01.10, EP 5) (For full text and any exceptions, refer to NFPA 101-2000: 9.6.4 and NFPA 72-1999: 1-5.6 and 3-8.4.1.3.3)



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP 2

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed that the Edwards fire panel was located behind the main desk area which was open to the lobby and did not have a smoke detector protecting it. This was verified by the Director of Plant Operations.

Chapter:

Life Safety

Program:

Hospital Accreditation

Standard:

LS.02.01.35

Standard Text:

The hospital provides and maintains systems for extinguishing fires.

Organization Identification Number: 7875

Page 25 of 50

Supplemental #1
March 27, 2018
11:42 am

Element(s) of Performance:

5. Sprinkler heads are not damaged and are free from corrosion, foreign materials, and paint. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.1.1)



Scoring Category: C

Score:

Partial Compliance

Observation(s):

EP 5

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Bullding Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed in the front lobby area that there were two dirty sprinkler heads in front of the main desk. This was verified by the Director of Plant Operations.

Observed In Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

It was observed in the front meeting that there were two dirty sprinkler heads above the front window. This was verified by the Director of Plant Operations.

Chapter:

Medical Staff

Program:

Hospital Accreditation

Standard:

MS.01.01.01

Standard Text:

Medical staff bylaws address self-governance and accountability to the governing

body.

March 27, 2018 11:42 am

Element(s) of Performance:

3. Every requirement set forth in Elements of Performance 12 through 36 is in the medical staff bylaws. These requirements may have associated details, some of which may be extensive; such details may reside in the medical staff bylaws, rules and regulations, or policies. The organized medical staff adopts what constitutes the associated details, where they reside, and whether their adoption can be delegated. Adoption of associated details that reside in medical staff bylaws cannot be delegated. For those Elements of Performance 12 through 36 that require a process, the medical staff bylaws include at a minimum the basic steps, as determined by the organized medical staff and approved by the governing body, required for implementation of the requirement. The organized medical staff submits its proposals to the governing body for action. Proposals become effective only upon governing body approval. (See the 'Leadership' (LD) chapter for requirements regarding the governing body's authority and conflict management processes.) Note: If an organization is found to be out of compliance with this Element of Performance, the citation will occur at the appropriate Element(s) of Performance 12 through 36.

Scoring Category: A

Score: Insufficient Compliance

16. For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The requirements for completing and documenting medical histories and physical examinations. The medical history and physical examination are completed and documented by a physician, an oralmaxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy. (For more information on performing the medical history and physical examination, refer to MS.03.01.01, EPs 6-11.) Note 1: The definition of 'physician' is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). Note 2: The requirements referred to in this element of performance are, at a minimum, those described in the element of performance and Standard PC.01.02.03, EPs 4 and 5.

Scoring Category: A

Score: Insufficient Compliance





Supplemental #1
March 27, 2018
11:42 am

Observation(s):

EP 3

§482.12(a)(4) - (A-0048) - [The governing body must:]

(4) Approve medical staff bylaws and other medical staff rules and regulations;

This Standard is NOT MET as evidenced by:

Observed in Regulatory Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

In review of medical staff bylaws it was noted that compliance with element of performance 16 in this standard was not met because the process for completing and documenting medical history and physical examinations was not described in sufficient detail to satisfy CoP 482.22 (c) (5) (i) - (A-0358)

EP 16

§482.22(c)(5)(i) - (A-0358) - (i) A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

This Standard is NOT MET as evidenced by:

Observed in Regulatory Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

The requirements for completing and documenting medical history and physical examination were not described in detail sufficient to specify exactly who may perform H&P's and required updates, the time frames involved, and the requirement for countersignature when applicable. The statement relating to H&P in the Bylaws simply referenced the related section in the medical staff Rules and Regulations.

Chapter: Medical Staff

Program: Hospital Accreditation

Standard: MS.03.01.01

Standard Text: The organized medical staff oversees the quality of patient care, treatment, and

services provided by practitioners privileged through the medical staff process.

Element(s) of Performance:

Practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff. 1

Scoring Category: A

Score: Insufficient Compliance

Observation(s):

Supplemental #1 March 27, 2018 11:42 am

EP 2

§482.22(a)(1) - (A-0340) - (1) The medical staff must periodically conduct appraisals of its members.

This Standard is NOT MET as evidenced by:

Observed in Record Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

The record of a patient who had undergone an operation by a podiatric surgeon under general anesthesia was reviewed. The record contained a preoperative H&P that had been documented by the podlatrist. During the credentialing session, it was confirmed that podiatrists at this hospital did not have privileges to perform H&Ps. In providing this service to this patient, this podiatrist was practicing outside the scope of his privileges as determined by the organized medical staff. The podiatrist was appropriately licensed and had been credentialed and privileged by the medical staff to perform the surgical procedure.

Observed in Record Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

On review of a second record of a patient who presented for a podiatric surgical procedure under anesthesia, it was noted that the H&P had been performed and documented by a nurse anesthetist. On review of the credentials file of a nurse anesthetist, it was noted that the specific privilege of performing general medical histories and physical examinations had not been granted to nurse anesthetists. The anesthetist had been granted specific privileges for performing examinations necessary to determine preanesthesia risk assessments, but not for a full medical H&P that would count as an admission H&P for other medical purposes. In performing the complete admission H&P for this podiatric patient, the anesthetist was practicing outside the scope of his privileges as determined by the medical staff.

Chapter:

Medical Staff

Program:

Hospital Accreditation

Standard:

MS.08.01.03

Standard Text:

Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing

privilege prior to or at the time of renewal.

Element(s) of Performance:

2. The process for the ongoing professional practice evaluation includes the following: The type of data to be collected is determined by individual departments and approved by the organized medical staff.

Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

Supplemental #1
March 27, 2018
11:42 am

EP 2

§482.22(a)(1) - (A-0340) - (1) The medical staff must periodically conduct appraisals of its members.

This Standard is NOT MET as evidenced by:

Observed in Medical Management Session at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for

the Hospital deemed service.

During tracer activity, record review, and subsequent discussion with medical staff members at the credentialing and privileging session, it was learned that a nurse anesthetist was independently performing pain management procedures utilizing lumbar epidural steroid injections. On review of the credentials file for this anesthetist, there was no documentation of a request from the anesthetist to perform this specific procedure, a procedure which was outside the scope of the privileges originally granted to him. The medical staff and anesthesia department had not proactively developed a process for monitoring this procedure by an anesthetist and had not determined the type of data to be collected for assessment. At the time of his most recent reappointment, there was no notation of the number of procedures he had done or the outcomes from the interventions during the pervious appointment cycle. This was the only anesthetist at the hospital performing lumbar epidural steroid injections.

Chapter:

Medication Management

Program:

Hospital Accreditation

Standard:

MM.03.01.01

Standard Text:

The hospital safely stores medications.

Element(s) of Performance:

 The hospital stores medications according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions.

Note: This element of performance is also applicable to sample medications.

Scoring Category: C

Score:

Partial Compliance

Observation(s):

ESC 60 days



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EP 2

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. During tracer activity on the Med-Surg unit it was noted that the documentation for the temperature in the medication refrigerator attached to the automated dispensing system was missing for November 29th. Hospital policy required daily documentation of refrigerator temperature to assure consistency of function.

Observed in Tracer Activities at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. Senior care unit: Temperatures were not continuously monitored in the dormitory style refrigerator that stored a box of influenza vaccines. Staff checked the refrigerator temperature once daily. The refrigerator was also observed to have a large amount of frost and ice formation.

Chapter:

Performance Improvement

Program:

Hospital Accreditation

Standard:

PI.02.01.01

ES

Standard Text:

The hospital compiles and analyzes data.

Element(s) of Performance:

4. The hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP 4

§482.21 - (A-0263) - §482.21 Condition of Participation: Condition of Participation: Quality Assessment and Performance Improvement Program

This Standard is NOT MET as evidenced by:

Observed in Data Session at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

While the hospital collected a large amount of data, there was no data analysis performed over time to identify variance in performance. There was a lack of evidence the hospital aggregated, analyzed, and compared internal data to identify patterns, trends, and variations over time. The hospital provided lists and spreadsheets of raw data including falls; restraints; elopement; harm to staff and patients; and hand hygiene compliance.

C	h	a	n	t	e	r	•

Provision of Care, Treatment, and Services

Supplemental #1

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Program:

Hospital Accreditation

Standard:

PC.01.02.08

Standard Text:

The hospital assesses and manages the patient's risks for falls.

Element(s) of Performance:

1. The hospital assesses the patient's risk for falls based on the patient population and setting.

1

Scoring Category: C

Score:

Partial Compliance

Observation(s):

EP 1

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. Senior Care unit: An initial assessment to determine the patient's risk for falls was not documented as required by the organization's policy #NSG 02-42: "Fall precaution assessment and rating". The patient was admitted to the hospital 11/18 but the first documented assessment for risk for falls was entered at 1916 on 11/19.

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. An Initial assessment to determine the patient's risk for falls was not documented as required by the organization's policy #NSG 02-42: "Fall precaution assessment and rating". The patient was admitted to the hospital 11/21 at 0630 but the first documented assessment for risk for falls was entered 11/22 at 1617.

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.01.02.13

Standard Text:

The hospital assesses the needs of patients who receive treatment for emotional

and behavioral disorders.

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Element(s) of Performance:

- 2. Patients who receive treatment for emotional and behavioral disorders receive an assessment that includes the following:
- Current mental, emotional, and behavioral functioning
- Maladaptive or other behaviors that create a risk to the patient or others
- Mental status examination
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Reason for admission as stated by the patient and/or others significantly involved in the patient's care
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Onset of the patient's illness and circumstances leading to admission
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Inventory of the patient's strengths and disabilities (such as psychiatric, biopsychosocial problems requiring treatment/intervention) written in a descriptive manner on which to base a treatment plan (See also PC.01.03.01, EP 1)

Scoring Category: A

Score: Insufficient Compliance

Observation(s):

Standard Text:

EP 2

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

For a patient's initial multidisciplinary treatment plan, there was a lack of a psychiatrist's signature by name and title. The organization's policy #BH 02-09: "Treatment planning" required those participating in the development of the treatment plan to sign the plan by name and title. (Note: This was obtained as a late entry on the last day of survey activities.)

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.02.01.11

Resuscitation services are available throughout the hospital.

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Element(s) of Performance:

2. Resuscitation equipment is available for use based on the needs of the population served. Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EP 2)



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Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP 2

Observed in Tracer Activities at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. Senior care unit: On 12/1/2015, the time of day displayed/printed on the defibrillator/monitor on the emergency resuscitation cart was incorrect. The time displayed/printed was 1605 but the actual time of day was 1430. The unit director reported the defibrillator/monitor tape was retained for documentation in the patient's medical record. (The time of day was observed to be corrected on site 12/2.)

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.04.01.05

Standard Text:

Before the hospital discharges or transfers a patient, it informs and educates the

patient about his or her follow-up care, treatment, and services.

Element(s) of Performance:

8. The hospital provides written discharge instructions in a manner that the patient and/or the patient's family or caregiver can understand. (See also RI.01.01.03, EP 1)



Scoring Category: C

Score:

Partial Compliance

Observation(s):

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EP8

Observed In Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. For a patient that received procedural sedation (ketamine and propofol) in the ED, the written discharge instructions lacked instructions specific to the sedation received.

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. For a patient that received procedural sedation (versed) in the ED, the written discharge instructions lacked instructions specific to the sedation received.

Chapter:

Record of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

RC.01.01.01

Standard Text:

The hospital maintains complete and accurate medical records for each individual

patient.

Element(s) of Performance:

 For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed.



Scoring Category: C

Score:

Partial Compliance

Observation(s):

EP 19

§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

The record of a patient who underwent placement of a dialysis catheter under anesthesia was reviewed. The surgeon had not dated or timed his authentication mark on the document for informed consent.

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site for the Hospital deemed service.

The practitioner's pre-procedural ECT orders and post-procedural ECT note lacked documentation of date and/or time.

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Chapter:

Care, Treatment, and Services

Program:

Behavioral Health Care Accreditation

Standard:

CTS.02.01.11

ESC 60 days

Standard Text:

The organization screens all individuals served for their nutritional status.

Note: Triggers for a nutritional assessment may include a weight loss or weight gain

of 10 pounds or more in the past three months, a change in appetite, dental problems, noncompliance with a special diet, and food allergies. (Refer to

CTS.02.03.09, EP 1 for more information)

Element(s) of Performance:

1. The organization screens all individuals served to identify those for whom a nutritional assessment is indicated.



Scoring Category: C

Score:

Partial Compliance

Observation(s):

EP 1

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. There was no process to screen Individuals served in the partial hospitalization process to identify those for whom a nutritional assessment was indicated. When asked, the nurse said that that this was not a part of the assessment process. This patient was not screened.

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. There was no process to screen individuals served in the partial hospitalization process to identify those for whom a nutritional assessment was indicated. When asked, the nurse said that that this was not a part of the assessment process. This patient was not screened.

Chapter:

Care, Treatment, and Services

Program:

Behavioral Health Care Accreditation

Standard:

CTS.03.01.01



Supplemental #1

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Standard Text:

The organization bases the planned care, treatment, or services on the needs,

strengths, preferences, and goals of the individual served.

Note: For opioid treatment programs: Methadone has well-documented effects on several systems, including the respiratory, nervous, and cardiac systems, and the liver. Additionally, many medications including methadone can act to increase the QT interval on an electrocardiogram and potentially lead to torsades de pointes, a potentially life-threatening cardiac arrhythmia. Therefore, it is important for the program physician to consider all of the medications the patient is currently taking (including actual versus prescribed doses, illicit drugs, medically active adulterants potentially present in illicit substances, and medically active over-the-counter or natural remedies). Given consideration of this information, the program physician can determine whether the treatment drug will be methadone, buprenorphine, or another medication and whether the treatment indicated for the patient is induction, detoxification, or maintenance.

Element(s) of Performance:

1. The needs, strengths, preferences, and goals of the individual served are identified based on the screening and assessment and are used in the plan for care, treatment, or services.



Scoring Category: C

Score:

Partial Compliance

Observation(s):

EP 1

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. The patient had several needs that were identified in the assessments and that he described in talking with him. These included finding a place to live where he could live with a roommate and returning to school to complete his education. However, they were not used in the treatment plan. The treatment plan included only the diagnoses.

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. The patient had several needs that were identified in the assessments and that he described in talking with him. In particular, he was interested in developing supportive relationships and being an outstanding grandfather. However, these needs and goals were were not used in the treatment plan. The treatment plan included only the diagnoses.

Chapter:

Care, Treatment, and Services

Program:

Behavioral Health Care Accreditation

Standard:

CTS.03.01.03

Standard Text:

The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

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Element(s) of Performance:

3. The objectives of the plan for care, treatment, or services meet the following criteria:

- They include identified steps to achieve the goal(s) (See also CTS.03.01.01, EP 3)

- They are sufficiently specific to assess the progress of the individual served

- They are expressed in terms that provide indices of progress

Scoring Category: C

Score :

Partial Compliance

Observation(s):

EP3

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. The objectives in the treatment plan did not include identified steps to achieve the goal and were not written In terms that were sufficiently precise to permit assessing the progress of the client.

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. The objectives in the treatment plan did not include identified steps to achieve the goal and were not written in terms that were sufficiently precise to permit assessing the progress of the client.

Chapter:

Care, Treatment, and Services

Program:

Behavioral Health Care Accreditation

Standard:

CTS.04.03.33

Standard Text:

For organizations providing food services: The organization has a process for

preparing and/or distributing food and nutrition products.

Element(s) of Performance:

3. For organizations providing food services: Food and nutrition products are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.

Scoring Category: A

Score:

Insufficient Compliance

Observation(s):





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EP3

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. The partial hospitalization program stored food and beverages used by patients in a refrigerator. There was a process to ensure that the proper temperature was maintained. However, it was ineffective. The designated temperature range was 33 to 40 degrees. The recorded temperature for 4 of the last 30 days had been out of range and no action had been taken. The current temperature on the thermometer in the refrigerator was out of range.

Chapter:

National Patient Safety Goals

Program:

Behavioral Health Care Accreditation

Standard:

NPSG.15.01.01

Standard Text:

Identify individuals at risk for suicide.

Element(s) of Performance:

1. Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk for suicide.

1

Scoring Category: C

Score:

Partial Compliance

Observation(s):

EP 1

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. The patient had been admitted with recent suicidal ideation and a suicide plan. There was no suicide risk assessment that included individual factors that both increase and decrease the risk of suicide.

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. The patient had been admitted with recent suicidal ideation. There was no suicide risk assessment that included individual factors that both increase and decrease the risk of suicide.

Opportunities for Improvement – Summary

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Program: Hospital Accreditation

Program

Standards: HR.01.04.01 EP4

HR.01.06.01 EP5

LS.02.01.30 EP2,EP23

MM.04.01.01 EP13

MM.05.01.01 EP11

NPSG.15.01.01 EP1

PI.02.01.01 EP1

RC.02.01.03 EP7

Program: Behavioral Health Care

Accreditation Program

Standards: CTS.02.02.01 EP1

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Opportunities for Improvement - Detail

Chapter:

Human Resources

Program:

Hospital Accreditation

Standard:

HR.01.04.01

Standard Text:

The hospital provides orientation to staff.

Element(s) of Performance:

4. The hospital orients staff on the following: Their specific job duties, including those related to infection prevention and control and assessing and managing pain. Completion of this orientation is documented. (See also IC.01.05.01, EP 6; IC.02.01.01, EP 7; IC.02.04.01, EP 2; RI.01.01.01, EP 8)



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

FP4

Observed in Competency Session at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. For the infection preventionist, there was a lack of documentation of orientation specific to the role and job duties of the infection preventionist.

Chapter:

Human Resources

Program:

Hospital Accreditation

Standard:

HR.01.06.01

Standard Text:

Staff are competent to perform their responsibilities.

Element(s) of Performance:

5. Staff competence is initially assessed and documented as part of orientation.



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

EP5

Observed in Competency Session at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. For the infection preventionist, there was a lack of documented evidence that an initial assessment of competency was completed specific to the role of the infection preventionist.

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Chapter:

Life Safety

Program:

Hospital Accreditation

Standard:

LS.02.01.30

Standard Text:

The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

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Element(s) of Performance:

- 2. All hazardous areas are protected by walls and doors in accordance with NFPA 101-2000: 18/19.3.2.1. (See also LS.02.01.10, EP 5; LS.02.01.20, EP 18) Hazardous areas include, but are not limited, to the following: Boiler/fuel-fired heater rooms
- Existing boiler/fuel-fired heater rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
- New boiler/fuel-fired heater rooms have sprinkler systems and have 1-hour fire-rated walls and 3/4-hour fire-rated doors.

Central/bulk laundries larger than 100 square feet

- Existing central/bulk laundries larger than 100 square feet have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the laundries have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
- New central/bulk laundries larger than 100 square feet have sprinkler systems and have 1-hour firerated walls and 3/4-hour fire-rated doors.
 Flammable liquid storage rooms (See NFPA 30-1996:4-4.2.1 and 4-4.4.2)
- Existing flammable liquid storage rooms have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors.
- New flammable liquid storage rooms have sprinkler systems and have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors.

Laboratories (See NFPA 45-1996 to determine if a laboratory is a 'severe hazard' area)

- Existing laboratories that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the laboratories have walls fire rated for 1 hour with 3/4-hour fire-rated doors.
- New laboratories that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices.
- Existing laboratories that are severe hazard areas (See NFPA 99-1999: 10-3.1.1) have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. When there is a sprinkler system, the walls are fire rated for 1 hour with 3/4-hour fire-rated doors.
- New laboratories that are severe hazard areas (See NFPA 99-1999: 10-3.1.1) have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- Existing flammable gas storage rooms in laboratories have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. (See NFPA 99-1999: 10-10.2.2)



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- New flammable gas storage rooms in laboratories have sprinkler systems and have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. (See NFPA 99 -1999: 10-10.2.2)
- Maintenance repair shops
- Existing maintenance repair shops have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the shops have 1-hour fire-rated walls with at least 3/4-hour fire-rated doors.
- New maintenance repair shops have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Piped oxygen tank supply rooms (See NFPA 99-1999: 4-3.1.1.2)

- Existing piped oxygen tank supply rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New piped oxygen tank supply rooms have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Paint shops that are not severe hazard areas

- Existing paint shops that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the shops have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New paint shops that are not severe hazard areas have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Soiled linen rooms

- Existing soiled linen rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New soiled linen rooms have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour firerated doors.

Storage rooms

- Existing storage rooms for combustible materials larger than 50 square feet have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New storage rooms for combustible materials 50 to 100 square feet are sprinklered, resist the passage of smoke, and have doors with self-closing or automatic-closing devices.
- New storage rooms for combustible materials larger than 100 square feet are sprinklered and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Trash collection rooms

- Existing trash collection rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices;

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or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

 New trash collection rooms are sprinklered and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Scoring Category: C

Score:

Satisfactory Compliance

23. Doors in smoke barriers are self-closing or automatic-closing, constructed of 1 3/4-inch or thicker solid bonded wood core or constructed to resist fire for not less than 20 minutes, and fitted to resist the passage of smoke. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 3/4 inch. Doors do not have nonrated protective plates more than 48 inches above the bottom of the door. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.7.5, 18/19.3.7.6, and 8.3.4.1)

Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

EP2

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. It was observed on the 2nd floor old ICU dialysis unit that a patient room had been converted into a hazardous storage room. The room was un-sprinkled and was approximately 160 square feet. The door was not self-closing and did not latch. There were 4 wooden pallets of cardboard boxed supplies stored there. This was verified by the Director of Plant Operations.

EP23

Observed in Building Tour at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. It was observed that the back door to Dietary that was in a 1 hour smoke wall and was equipped with a closer and latching hardware did not latch. This was verified by the Director of Engineering.

Chapter:

Medication Management

Program:

Hospital Accreditation

Standard:

MM.04.01.01

Standard Text:

Medication orders are clear and accurate.

Element(s) of Performance:

13. The hospital implements its policies for medication orders.

Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):



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EP13

Observed in Record Review at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. The record of a patient who underwent a surgical procedure by a podlatrist was reviewed. In the post operative orders, the podiatrist had written "resume all pre op meds". This order was not deemed acceptable by hospital pharmacy policy.

Chapter:

Medication Management

Program:

Hospital Accreditation

Standard:

MM.05.01.01

Standard Text:

A pharmacist reviews the appropriateness of all medication orders for medications to

be dispensed in the hospital.

Element(s) of Performance:

11. After the medication order has been reviewed, all concerns, issues, or questions are clarified with the individual prescriber before dispensing.



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

EP11

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site.

During tracer activity on the Med-Surg unit, the record of a patient who had undergone an orthopedic procedure the previous day was reviewed. The physician had ordered both Dilaudid and Morphine "for pain". Both orders had been reviewed by the pharmacist and were active in the MAR. The physician had not specified the pain level to prompt intervention or the sequence in which the two therapeutic options should be utilized. The questions had not been clarified with the prescriber by the pharmacist before entering the orders into the MAR.

Chapter:

National Patient Safety Goals

Program:

Hospital Accreditation

Standard:

NPSG.15.01.01

Standard Text:

Identify patients at risk for suicide.

Note: This requirement applies only to psychiatric hospitals and patients being

treated for emotional or behavioral disorders in general hospitals.

Element(s) of Performance:

 Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

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EP1

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. For a patient admitted to the Dual Diagnosis unit, the patient's risk for suicide was not accurately assessed as required by the organization's policy. The patient's risk was scored 17 (defined by the organization as low risk) but not accurately documented as 27 (defined by the organization as moderate risk). The organization's policy #02-38: Suicide risk assessment" required staff to complete the initial suicide risk assessment as part of the initial admission assessment.

Chapter:

Performance Improvement

Program:

Hospital Accreditation

Standard:

PI.02.01.01

Standard Text:

The hospital compiles and analyzes data.

Element(s) of Performance:

1. The hospital compiles data in usable formats.



Scoring Category : C

Score:

Satisfactory Compliance

Observation(s):

EP1

Observed in Data Session at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. There was a lack of evidence the hospital compiled data in usable formats. Data such as; falls, restraints, elopement, episodes of harm to staff and patients, and hand hygiene compliance were presented as raw data in lists and spreadsheets.

Chapter:

Record of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

RC.02.01.03

Standard Text:

The patient's medical record documents operative or other high-risk procedures and

the use of moderate or deep sedation or anesthesia.

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Element(s) of Performance:

7. When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis.

1

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Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

EP7

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site.

During tracer activity on the Med-Surg unit, the record of a patient who had undergone an orthopedic operation the previous day was reviewed. No documentation of an immediate post procedure progress note could be located. A full operative note had been dictated by the surgeon later in the day and subsequently transcribed that evening. However, there was no concurrent note in the record to provide information which may have been required by caregivers during that time interval.

Chapter:

Care, Treatment, and Services

Program:

Behavioral Health Care Accreditation

Standard:

CTS.02.02.01

Standard Text:

The organization collects assessment data on each individual served.

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Element(s) of Performance:

- 1. As relevant to care, treatment, or services, the organization collects the following assessment data about each individual served:
- Environment and living situation(s)
- Leisure and recreational interests
- Religion or spiritual orientation
- Cultural preferences
- Childhood history
- Military service history, if applicable
- Financial issues
- Usual social, peer-group, and environmental setting(s)
- Language preference and language(s) spoken
- Ability to self-care
- Family circumstances, including bereavement
- Current and past trauma
- Community resources accessed by the individual served

Note 1: Relevance to care, treatment, or services may be determined by the individual's presenting needs and the organization's scope of care, treatment, or services.

Note 2: For certain populations, early identification of community resources is important to care, treatment, or services. Such populations include individuals with severe mental illness or disabilities and children and youth. Community resources for these groups encompass a wide range of services. These services are supportive (such as community mental health, sheltered living, day treatment, or activity programs) as well as commonly accessed by the general public (such as public transportation, banking, or retail stores). For youth or children in foster care or in-home services, resources might include community mental health centers, teen centers, YMCAs, or Jewish community centers. These sources of community services may be used as informational, discharge planning, supportive, or continuing care resources.

Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

FP1

Observed in Individual Tracer at DMC - Memphis, Inc. (3000 Getwell Road, Memphis, TN) site. There was a process for completing a psychosocial assessment. However, for these patient, it was not followed. A very brief assessment had been done with only a few items. The person who completed the assessment stated that when a patient is transferred from another hospital, as this patient was, this is the policy. When asked for the policy, it could not be found. There was no completed psychosocial assessment of updated psychosocial assessment for this patient.



Supplemental #1

The Joint Commission

March 27, 2018 11:42 am

Plan for Improvement - Summary

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Number of PFIs: 1

Site: DMC - Memphis, Inc.

Building Name: Delta Medical Center_HAP

PFI Id: DMC1501

Description:

Sprinkler piping supporting other items

ILSM Access:

Projected Completion Date: 12/10/2016

Funds Committed: No

Accepted Date: 12/3/2015



Official Accreditation Report

TrustPoint Hospital LLC 1009 N. Thompson Ln. Murfreesboro, TN 37129

Organization Identification Number: 528362

Unannounced Full Event: 9/9/2015 - 9/10/2015

Supplemental #1
March 27, 2018
11:42 am

Report Contents

Executive Summary

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Opportunities for Improvement

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Plan for Improvement

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

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Executive Summary

Program(s)
Hospital Accreditation

Survey Date(s) 09/09/2015-09/10/2015

Hospital Accreditation:

As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Organization Identification Number: 528362

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Requirements for Improvement – Summary

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site:

Program:

Hospital Accreditation

Program

Standards:

EC.04.01.01

EP15

PC.02.01.11

EP2

RI.01.03.01

EP9

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

Program:

Hospital Accreditation

Program

Standards:

EC.01.01.01

EP3

EC.02.03.05

EP13,EP18,EP20

EC.04.01.03

EP3

EM.02.02.11

EP3

EM.03.01.01

EP2,EP4

LD.04.01.05

EP4

LD.04.04.01

EP25

MS.08.01.03

EP3

PC.01.02.03

EP5

RC.01.02.01

EP4

The Joint Commission **Summary of CMS Findings**

Supplemental #1 March 27, 2018

11:42 am

CoP:

Text:

§482.13

Tag: A-0115

Deficiency: Standard

Corresponds to: HAP

§482.13 Condition of Participation: Patient's Rights

A hospital must protect and promote each patient's rights.

CoP Standard	Tag	Corresponds to	Deficiency
§482.13(b)(2)	A-0131	HAP - RI.01.03.01/EP9	Standard

CoP:

§482.24

Tag: A-0431

Deficiency: Standard

Corresponds to: HAP

Text:

§482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(2)	A-0450	HAP - RC.01.02.01/EP4	Standard

CoP:

§482.41

Tag: A-0700

Deficiency: Standard

Corresponds to: HAP

Text:

§482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(c)(2)	A-0724	HAP - EC.02.03.05/EP13, EP18, EP20, EC.04.01.01/EP15	Standard
§482.41(a)	A-0701	HAP - EC.01.01.01/EP3, EM.02.02.11/EP3	Standard

CoP:

§482.51

Tag: A-0940

Deficiency: Standard

Corresponds to: HAP

Text:

§482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

CoP Standard	Tag	Corresponds to	Deficiency
§482.51(b)(1)(i)	A-0952	HAP - PC.01.02.03/EP5	Standard

The Joint Commission Summary of CMS Findings

Supplemental #1

March 27, 2018

11:42 am

CoP:

§482.22

Tag: A-0338

Deficiency: Standard

Corresponds to: HAP

Text:

§482.22 Condition of Participation: Medical staff

The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical

care provided to patients by the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.22(a)(1)	A-0340	HAP - MS.08.01.03/EP3	Standard

Requirements for Improvement - Detail

Chapter:

Emergency Management

Program:

Hospital Accreditation

Standard:

EM.02.02.11

Standard Text:

As part of its Emergency Operations Plan, the hospital prepares for how it will

manage patients during emergencies.

Element(s) of Performance:

3. The Emergency Operations Plan describes the following: How the hospital will evacuate (from one section or floor to another within the building, or, completely outside the building) when the environment cannot support care, treatment, and services. (See also EM.02.02.03, EPs 9 and 10)



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP3

§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.

This Standard is NOT MET as evidenced by:

Observed in Emergency Management Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

The hospitals EOP and it's Fire plan does not address how the hospital will evacuate to the outside of the building when the environment cannot support care, treatment, and services.

Chapter:

Emergency Management

Program:

Hospital Accreditation

Standard:

EM.03.01.01

ESC 60 days

Standard Text:

The hospital evaluates the effectiveness of its emergency management planning

activities.

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Element(s) of Performance:

2. The hospital conducts an annual review of the objectives and scope of its Emergency Operations Plan. The findings of this review are documented.



Scoring Category: A

Score:

Insufficient Compliance

4. The annual emergency management planning reviews are forwarded to senior hospital leadership for review. (See also LD.04.04.01, EP 25) Note: Senior hospital leadership refers to those leaders with responsibility for organizationwide strategic planning and budgets (vice presidents and officers). The hospital may determine that all senior hospital leaders participate in reviewing emergency management reviews, or it may designate specific senior hospital leaders to review this information.



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP 2

Observed In Emergency Management Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site.

For 2014 and the first 8 months of 2015 - The hospital has not conducted an annual review of the objectives and scope of its Emergency Operations Plan

EP 4

Observed in Emergency Management Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site.

For 2014 and the first 8 months of 2015 - The hospital has not conducted an annual review of the objectives and scope of its Emergency Operations Plan. Therefore the annual emergency management planning review has not been forwarded to senior hospital leadership for review.

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.01.01.01

Standard Text:

The hospital plans activities to minimize risks in the environment of care.

Note: One or more persons can be assigned to manage risks associated with the

management plans described in this standard.

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Element(s) of Performance:

3. The hospital has a written plan for managing the following: The environmental safety of patients and everyone else who enters the hospital's facilities. (See also EC.04.01.01, EP 15)



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP3

§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.

This Standard is NOT MET as evidenced by:

Observed in Environment of Care Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In reviewing the Safety Management Plan (Policy 15.053) presented to this surveyor, the plan appears to be directly copied from another Hospital and is not accurate for this hospital.. Example -The Safety Management Plan is dated "reviewed in 12/10/2010" - However this hospital did not open till 2012.

Also in section B-1-e,f,and g the Safety Plan discusses activities to be done by a Texas regulatory authorities Note, This hospital is located in Murfreesboro TN

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.02.03.05

Standard Text:

The hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance,

testing, and inspection requirements apply.

Element(s) of Performance:

13. Every 6 months, the hospital inspects any automatic fire-extinguishing systems in a kitchen. The completion dates of the inspections are documented.

Note 1: Discharge of the fire-extinguishing systems is not required.

Note 2: For additional guidance on performing inspections, see NFPA 96, 1998 edition.

Scoring Category: A

Score:

Insufficient Compliance

18. The hospital operates fire and smoke dampers 1 year after installation and then at least every 6 years to verify that they fully close. The completion date of the tests is documented.

Note 1: The initial test that must occur 1 year after installation applies only to dampers installed on and after January 1, 2008.

Note 2: For additional guidance, see NFPA 80 Standard for Fire Doors and Other Opening Protectives, 2007 edition (Section 19.4.1.1) and NFPA 105, 2007 edition (Section 6.5.2).

Scoring Category: C

Score:

Partial Compliance

20. Every 12 months, the hospital tests sliding and rolling fire doors for proper operation and full closure. The completion date of the tests is documented.

Note: For additional guidance on performing tests, see NFPA 80, 1999 edition (Section 15-2.4).

Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

A





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EP 13

§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

This Standard is NOT MET as evidenced by:

Observed in Document Review at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

For 2014 and 2015 - The hospital's documentation indicates that the kitchen hood extinguishment system was tested on 4/15, 7/14 and 4/14, which is 3 months and 9 months apart, not every 6 months as required by the standard.

EP 18

§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

This Standard is NOT MET as evidenced by:

Observed in Document Review at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

For the 1st floor - The hospital had it's initial (new installation) fire damper inspection during 7/2012. The hospital does not have documentation that it conducted a 1 year after installation, fire and smoke damper test and inspection.

Observed in Document Review at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

For the 2nd floor - The hospital had it's initial (new installation) fire damper inspection during 7/2012. The hospital does not have documentation that it conducted a 1 year after installation, fire and smoke damper test and inspection.

EP 20

§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

This Standard is NOT MET as evidenced by:

Observed in Document Review at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

For 2013 and 2014 - The hospital does not have documentation that annually it has conducted a test and inspection of it's 2 rolling fire doors. (dish room and loading dock)

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.04.01.01

Standard Text:

The hospital collects information to monitor conditions in the environment.

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1

Element(s) of Performance:

15. Every 12 months, the hospital evaluates each environment of care management plan, including a review of the plan's objectives, scope, performance, and effectiveness. (See also EC.01.01.01, EPs 3-8; EC.04.01.03, EP 1)

Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

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EP 15

§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

This Standard is NOT MET as evidenced by:

Observed in Environment of Care Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In reviewing the hospitals Annual review of it's management plans for the year 2014 - the reviews do not indicate current and accurate information relating to the plans objectives, scope, performance, and effectiveness. For example - The Security Management plan review section "Security Management Plan Includes" discussed information from 2012 and activities to be implemented in 2013. There is no information for 2014 in this section.

Observed in Environment of Care Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In reviewing the hospitals Annual review of it's management plans for the year 2014 - the reviews do not indicate current and accurate information relating to the plans objectives, scope, performance, and effectiveness. For example - The Security Management Plan review section "Traffic Control" discusses Controlling access to the ER, OR, Peds. and Nursery. This hospital does not have these departments.

Observed in Environment of Care Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In reviewing the hospitals Annual review of it's management plans for the year 2014 - the reviews do not indicate current and accurate information relating to the plans objectives, scope, performance, and effectiveness. For example - The Hazardous Materials Plan review section "Hazardous Materials Inventory" discusses actions related to a MSDS program to be implemented and evaluated in 2013. There is no information or data for 2014.

Observed in Environment of Care Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In reviewing the hospitals Annual review of it's management plans for the year 2014 - the reviews do not indicate current and accurate information relating to the plans objectives, scope, performance, and effectiveness. For example - Utility Management Plan review section "Emergency Generator Testing" The review states the generator was tested under "50% full connected load each month". However during the review of the generator test records earlier in the survey with the hospital's engineer, it was noted that the generator does not always meet 30% load and therefore the hospital must do an annual load bank test.

Observed in Environment of Care Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In reviewing the hospitals Annual review of it's management plans for the year 2014 - the reviews do not indicate current and accurate information relating to the plans objectives, scope, performance, and effectiveness. For example - Under the review section "Miscellaneous" the review discusses the 2012 and 2013 PII actions but there is no information related to a 2014 PII project.

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.04.01.03

Standard Text:

The hospital analyzes identified environment of care issues.

Organization Identification Number: 528362

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Element(s) of Performance:

3. Annually, representatives from clinical, administrative, and support services recommend one or more priorities for improving the environment of care.



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Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP3

Observed in Environment of Care Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site.

In reviewing the hospitals Annual review of it's management plans for the year 2014 - The review discusses 2012 and 2013 PII actives but there is no information or data related to clinical, administrative, and support services recommending one or more priorities for improving the environment of care during 2014 or for PII activities to be conducted during 2015.

Chapter:

Leadership

Program:

Hospital Accreditation

Standard:

LD.04.01.05

Standard Text:

The hospital effectively manages its programs, services, sites, or departments.

Element(s) of Performance:

4. Staff are held accountable for their responsibilities.



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP 4

Observed in Document Review at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN)

Staff are not held accountable for their responsibilities, as indicated by Life Safety findings at Standard EC 02.03.05, EPs 13, 18 and 20.

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Chapter:

Leadership

Program:

Hospital Accreditation

Standard:

LD.04.04.01

Standard Text:

Leaders establish priorities for performance improvement. (Refer to the

'Performance Improvement' [PI] chapter.)

Element(s) of Performance:

25. Senior hospital leadership directs implementation of selected hospitalwide improvements in emergency management based on the following:

- Review of the annual emergency management planning reviews (See also EM.03.01.01, EP 4)
- Review of the evaluations of all emergency response exercises and all responses to actual emergencies (See also EM.03.01.03, EP 15)
- Determination of which emergency management improvements will be prioritized for implementation, recognizing that some emergency management improvements might be a lower priority and not taken up in the near term

Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP 25

Observed in Emergency Management Session at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site.

For 2014 and the first 8 months of 2015 - The hospital has not conducted an annual review of the objectives and scope of its Emergency Operations Plan. Therefore the annual emergency management planning review has not been forwarded to senior hospital leadership for review. This prevents senior leadership from directing implementation of selected hospital wide improvements in emergency management

Chapter:

Medical Staff

Program:

Hospital Accreditation

Standard:

MS.08.01.03

Standard Text:

Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing

Maintain existing privilege(s), to revise existing privilege(s), or to reve

privilege prior to or at the time of renewal.

A

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Element(s) of Performance:

3. The process for the ongoing professional practice evaluation includes the following: Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s).



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP3

§482.22(a)(1) - (A-0340) - (1) The medical staff must periodically conduct appraisals of its members.

This Standard is NOT MET as evidenced by:

Observed in Medical Management Session at TrustPoint Hospital LLC (1009 North Thompson Lane,

Murfreesboro, TN) site for the Hospital deemed service.

In discussion with the medical staff office and review of physicians files, it was observed the OPPE process did not begin until April,2015. The hospital opened in 2012, therefore the reappointment process for physicians did not include OPPE data in 2014.

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.01.02.03

Standard Text:

The hospital assesses and reassesses the patient and his or her condition according

to defined time frames.

Element(s) of Performance:

5. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 8; RC.02.01.03, EP 3)



Scoring Category: C

Score:

Partial Compliance

Observation(s):

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EP 5

§482.51(b)(1)(i) - (A-0952) - (i) A medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration.

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

Noted on the chart the anesthesia's history and physical update was not completed.

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In tracer activity and review of the record, noted the anesthesia history and physical updated was not completed.

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.02.01.11

ESC 45 days

Standard Text:

Resuscitation services are available throughout the hospital.

Element(s) of Performance:

2. Resuscitation equipment is available for use based on the needs of the population served.

Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EP 2)



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

EP 2

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN)

Noted resuscitative equipment on the medical psychiatric unit had not been checked in a manner consistent with organization policy on 9/2 and 9/4. On 9/4 a defibrillator strip was posted, but there was no documentation that the suction, oxygen tank or crash cart lock had been checked. On 9/2 there was not documentation that any of the resuscitative equipment had been checked.

С	h	a	p	t	е	r	

Record of Care, Treatment, and Services

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Program:

Hospital Accreditation

Standard:

RC.01.02.01

Standard Text:

Entries in the medical record are authenticated.

Element(s) of Performance:

4. Entries in the medical record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author.

Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key. Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or hospital policy. For electronic records, electronic signatures will be date -stamped.

Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: All orders, including verbal orders, are dated and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient, and who, in accordance with hospital policy; law and regulation; and medical staff bylaws, rules, and regulations, is authorized to write orders.

Scoring Category: C

Score:

Insufficient Compliance

Observation(s):

ESC 60 days



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EP 4

§482.24(c)(2) - (A-0450) - (2) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In review of the medical record during tracer activity, progress notes by the physician were not being signed in the time frame defined by hospital policy.

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In tracer activity, noted the progress notes written by the attending physician were not signed in the time frame defined by policy.

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In review of the medical review ,noted the psychiatric evaluation was not signed in the time frame defined by policy.

Observed in Document Review at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

During review of medical record of patient who was placed in behavioral restraints noted physician did not authenticate telephone order for restraints. Organization policy #: NUR 0012: Restraint and Seclusion, revision date 12/21/13, required the ordering physician to personally sign, time and date the telephone order within 24 hours of the time the order was originally issued.

Chapter:

Rights and Responsibilities of the Individual

Program:

Hospital Accreditation

Standard:

RI.01.03.01

Standard Text:

The hospital honors the patient's right to give or withhold informed consent.

Element(s) of Performance:

9. The informed consent process includes a discussion about potential benefits, risks, and side effects of the patient's proposed care, treatment, and services; the likelihood of the patient achieving his or her goals; and any potential problems that might occur during recuperation.



Scoring Category: A

Score:

Insufficient Compliance

Observation(s):

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EP9

§482.13(b)(2) - (A-0131) - (2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In tracer activity and review if the clinical chart, noted there was not any documentation in the record that the anesthesiologist had a discussion with the patient or family members, about the risks, benefits, side effects of the proposed anesthesia treatment

Observed In Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site for the Hospital deemed service.

In discussion with the staff and review of the medical record on a patient who received a PICC line, there was not any documentation by the physician about the risks of the proposed treatment.

Organization Identification Number: 528362

Opportunities for Improvement – Summary

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Program:	Hospital Accreditation Program	
Standards:	EC.02.06.01	EP1
	IC.02.02.01	EP4
	LS.02.01.10	EP5
	LS.02.01.30	EP18
	LS.02.01.35	EP4
	MM.05.01.01	EP8
	NPSG.15.01.01	EP1,EP2
	PC.01.03.01	EP23

Supplemental #1
March 27, 2018
11:42 am

Opportunities for Improvement – Detail

Chapter:

Environment of Care

Program:

Hospital Accreditation

Standard:

EC.02.06.01

Standard Text:

The hospital establishes and maintains a safe, functional environment.

Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services

appropriate to the needs of the community.

Element(s) of Performance:

 Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

EP1

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site. During tracer on medical psychiatric unit noted patient identified as suicidal was housed in a non-ligature proof room. The room has an extended shower head and sink faucet in addition to a standard hospital bed and call bell cords. Patient was transferred to the adult psychiatric unit on the second floor.

Chapter:

Infection Prevention and Control

Program:

Hospital Accreditation

Standard:

IC.02.02.01

Standard Text:

The hospital reduces the risk of infections associated with medical equipment,

devices, and supplies.

Element(s) of Performance:

4. The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

Supplemental #1
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EP4

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site. During tracer on medical psychiatric unit noted two blood collection tubes that expired 8/15 and were stored ready for use in a mobile blood drawing tray.

Chapter:

Life Safety

Program:

Hospital Accreditation

Standard:

LS.02.01.10

Standard Text:

Building and fire protection features are designed and maintained to minimize the

effects of fire, smoke, and heat.

Element(s) of Performance:

5. Doors required to be fire rated have functioning hardware, including positive latching devices and self-closing or automatic-closing devices. Gaps between meeting edges of door pairs are no more than 1/8 inch wide, and undercuts are no larger than 3/4 inch. (See also LS.02.01.30, EP 2; LS.02.01.34, EP 2) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1, 8.2.3.2.1 and NFPA 80-1999: 2-4.4.3, 2-3.1.7, and 1 -11.4)



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

EP5

Observed in Building Tour at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site. Main electrical room - the gap between the meeting edges of the double, 1 hour rated fire doors is over 1/8 inch.

Chapter:

Life Safety

Program:

Hospital Accreditation

Standard:

LS.02.01.30

Standard Text:

The hospital provides and maintains building features to protect individuals from the

hazards of fire and smoke.

Supplemental #1
March 27, 2018
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Element(s) of Performance:

18. Smoke barriers extend from the floor slab to the floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces), and extend continuously from exterior wall to exterior wall. All penetrations are properly sealed. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.7.3)



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

EP18

Observed In Building Tour at TrustPoint Hospital LLC (1009 North Thompson Lane,Murfreesboro,TN) site. Above the smoke doors in the hall to the Senior unit. There is an un sealed penetration in the smoke wall. Note - this was repaired during the survey.

Chapter:

Life Safety

Program:

Hospital Accreditation

Standard:

LS.02.01.35

Standard Text:

The hospital provides and maintains systems for extinguishing fires.

Element(s) of Performance:

4. Piping for approved automatic sprinkler systems is not used to support any other item. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.2)



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

EP4

Observed in Building Tour at TrustPoint Hospital LLC (1009 North Thompson Lane,Murfreesboro,TN) site. Above the double smoke doors by the Private Dining room - A large bundle of iT wiring has been plastic cable tied to the sprinkler piping..

Chapter:

Medication Management

Program:

Hospital Accreditation

Standard:

MM.05.01.01

Standard Text:

A pharmacist reviews the appropriateness of all medication orders for medications to

be dispensed in the hospital.

Supplemental #1 March 27, 2018 11:42 am

Element(s) of Performance:

8. All medication orders are reviewed for the following: Therapeutic duplication.



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

EP8

Observed in Tracer Activities at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site. Noted in the medical record during tracer activity, two pain medications were ordered without clear guidelines to the nursing staff on which medication to use first.

Chapter:

National Patient Safety Goals

Program:

Hospital Accreditation

Standard:

NPSG.15.01.01

Standard Text:

Identify patients at risk for suicide.

Note: This requirement applies only to psychiatric hospitals and patients being

treated for emotional or behavioral disorders in general hospitals.

Element(s) of Performance:

1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.



Scoring Category: C

Score:

Satisfactory Compliance

2. Address the patient's immediate safety needs and most appropriate setting for treatment.



Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

Supplemental #1 March 27, 2018 11:42 am

EP1

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane,Murfreesboro,TN) site. During tracer on medical psychiatric unit noted risk assessment that identified specific environmental features that may increase the risk of suicide was not completed prior to or during a period in which a suicidal patient was housed on the unit. A total of 12 small and large nall clippers, and two one quart bottles of cleaning solution were stored in unlocked cabinets in an area that was not supervised 100% of the time and was easily accessible via the main hallway used by patients and anyone entering the unit.

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane,Murfreesboro,TN) site. During a tracer on the medical psychiatric unit staff were not able to verbalize a coherent plan to accomplish the every 15 minute checks required by the organization to keep a suicidal patient housed on their unit safe. A video camera was in use in the patient room, but the camera outputs were not being continuously monitored or recorded for future review.

Chapter:

Provision of Care, Treatment, and Services

Program:

Hospital Accreditation

Standard:

PC.01.03.01

Standard Text:

The hospital plans the patient's care.

Element(s) of Performance:

23. The hospital revises plans and goals for care, treatment, and services based on the patient's needs. (See also RC.02.01.01, EP 2)

Scoring Category: C

Score:

Satisfactory Compliance

Observation(s):

FD23

Observed in Individual Tracer at TrustPoint Hospital LLC (1009 North Thompson Lane, Murfreesboro, TN) site. During tracer on medical psychiatric unit noted nursing care plans in 3 of 4 patient records reviewed did not reflect active medical or psychosocial issues identified during assessment.

Supplemental #1
March 27, 2018
11:42 am

Plan for Improvement - Summary

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Number of PFIs:

0

Agency at or prior to the consideration of the application by the Agency, westered

March 27. The facility is licensed for 66 Mental Health Hospital beds by the Department of Mental Health and Substance Abuse Services. These consist of 33 adult psychiatric beds, 16 child/adolescent psychiatric beds, and 17 adult dual diagnosis/substance Nashville, TN 37243 Pursuant to TCA Sec. 68-11-1607(c)(1): (A) any health care institution wishing to oppose a Certificate of Need application must file a written objection with perent and Development Agency no later than fitteen (15) days before regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled, and (B) any other person wishing to oppose application must file written objection with the Health Services and Development Agency at or prior to the consideration of the annication has the American Development The antitopated date of filling the application is on or before March 15, 2018. The contact person for the project is John Weilborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215, (615) 665-2022. Upon written request by interested parties, a local Fact-Finding public hearing This project proposes to increase total licensed beds to 80 beds. The adult units will be increased to 36 beds (increase of 3). The child/adolescent units will be increased to 32 beds (increase of 16). The dual diagnosis/substance abuse beds will be reduced from 17 beds to 12 beds (decrease of 5). All bed increases will be add fourteen (14) licensed beds to its facility at 9485 Crestwyn Hills Cove, Memphis, TN 38125, at a capital cost estimated at \$100,000. in existing semi-private size patient rooms that are currently used as single rooms. The project requires no construction. The project does not contain major medical shall be conducted. Written requests for hearing should be sent to the following

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modern facility. 5 people
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ty, Tennessee, are hereby notified that, pursuant to \$40-12-105 of the Tennessee Code Annotated, relative to grand jury proceedings, it is the duty of your grand jurors to investigate any public offense which they know or have reason to believe has been committed and which is triable or indictable in this county. Any person having knowledge or proof that such an offense has been committed may apply to testify before the grand jury subject to the provisions of Tennessee. Code Annotated

he forepersons in this

County are presently.

Mr. Jp. Vincent
201 Poplar Avenue
Memphis, Tennessee 38103
The grand jury will next meet
on Tuesday, the 20th day of
March, 2018, at 9:00 A.M. in
the Grand Jury Meeting Room,
201 Poplar Avenue, Memphis,
Tennessee 38103, You may
be prosecuted for perjury for
any oral or written statement
which you make under oath to
the grand jury, when you know
the statement to be false, and
when the statement to be false, and
when the statement to be false, and
when the statement to che
on a matter material to the

Richard L. DeSaussure, III Criminal Court Clerk Shelby County, Tennessee APPROVED: Marcy Ingram County Attorney



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and all interested parties, in accordance with T.C.A. Sections 68-11-1801 et seq. and the Rules of the Health Services and Development Agency, that Crestwon, Behavioral Health (a behavioral health hospital), owned and managed by Crestwon Health Group, LLC (a limited liability company), intends to file an application for a Certificate of Need to This is to provide official notice to the Health Services and Development Agency MAR 10, 11 Sat 9-2 Sun @10.

1457 Sutton Meadow Ln., 38016
Houston Levee/Pisgah Cordova
Sold House Full. Leather Sofa/
Recliners, Beds, Desk, KIT.
Garage Full., Electr., GUY
Clothes, Security, Sell All, No
Early Sales No Bags, Must
Move Your PAID items. 3%
CC. Not Responsible For Accidents, See pics Todd's Auction Service | Upcoming-Sales aquaTreasures Estate Sales -901-488-0640 Lamar Todd

COMMERCIALAPPEAL.COM & SATURDAY, MARCH 10, 2018 1 3D

Legal Morices

TO APPLY FOR A CERTIFICATE OF NEED

NOTIFICATION OF INTENT



abuse beds.

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equipment or initiate or discontinue any health service.

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Tennessee Health Services and Development Agency

Andrew Jackson Building, 9th Floor

500 Deaderick Street

Health Services and Development Agency

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П

Supplemental #2 (Original)

Crestwyn Behavioral Health

CN1803-018

11:59 A.M.

March 28, 2018

Phillip M. Earhart, HSD Examiner Tennessee Health Services and Development Agency Andrew Jackson Building, 9th Floor 502 Deaderick Street Nashville, TN 37243

RE: CON Application CN1803-018

Crestwyn Behavioral Health

Dear Mr. Earhart:

This letter responds to your second supplemental request for additional information on this application. The items below are numbered to correspond to your questions.

1. Section B, Need, Item 3 Incidence and Prevalence (Psychiatric Inpatient Services-Service Specific Criteria-) Page 24

Your response to this item is noted. Using the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) web-site, please compare the prevalence of serious mental illness in Shelby County to the other 6 regions in the state.

The table below compares the Regional rates of mental health hospital admissions to TDMHSAS hospitals and hospitals with whom the Department contracts. The table compares all seven TDMHSAS Planning and Policy Regions with one another and with the State rate. Although it does not cover admissions to private facilities, who outnumber TDMHSAS facilities, it does provide a perspective of serious mental illness across the State and in the project service area, insofar as that impacts State facilities. Shelby County had an admission rate of 2.1 per 1,000 adult population in FY2016. That was below the State average of 2.3. and lower than 5 out of the other 6 regions. Attached after this page is the Department's county-level detail, from which this table on this page is taken.

Inpatient Psychiatric Admissions I to TDMHSAS Affiliate Adults 18+ Years	ed Facilities	pulation	
PPR	2014	2015	2016
1-Upper East Tennessee	3.1	3.4	3.5
2-East Tennessee	1.9	2.3	2.2
3-Upper Cumberland	2.6	2.9	2.5
4-Upper Middle Tennessee	3.2	3.3	3.3
5-Southern Middle Tennessee	1.7	1.7	1.7
6-West Tennessee (Excluding Shelby County)	1.7	1.8	2.6
7-Shelby County	2.2	2.1	2.1
State of Tennessee	2.2	2.4	2.3

Substance Abuse Services Mental Health &

Department of

County and Region Services Data Book 2017 Tennessee Behavioral Health

September 2017

Division of Planning, Research and Forensics Xinqing Deng, MD, MPH and Rachel L. Jones Office of Research Prepared by:

Department of Mental Health & Substance Abuse Services

Table 43. Number of admissions and rate per 1,000 population 18+ years by Planning and Policy Regions and counties

																														-	rei fir	a gar	161	1881	G 11	8 6.4	AR
91	Rate	*	1.1	1.8	*	1.6	*	2.1	9.0	1.7	1.7	2.6	2.2	*	*	*	1.9	1.3	1.3	6.3	2.1	1.6	1.2	6.0	*	2.6	1.5	2.1	1.3	M Ci	i	8	A.	M	2.3	P	18
FY2016	#	12	59	407	16	209	15	29	96	162	2,145	34	49	12	6	12	54	39	48	130	43	22	25	24	<5	55	115	42	31	55	30	833	1,485	649	12,284		Rottom 25%
15	Rate	*	1.1	1.7	*	1.6	*	1.9	0.7	1.4	1.7	3.3	2.1	1.6	*	2.5	1.9	1.0	1.4	5.4	1.8	1.1	1.6	1.2	*	1.8	2.1	2.1	1.2	1.0	1.4	1.8	2.1	,	2.4		
FY2015	#	11	55	388	12	217	15	26	113	139	2,142	42	45	22	6	23	56	30	52	112	36	15	35	30	<5	38	156	42	29	45	39	859	1,480	635	12,646		Ton 25%
4	Rate	ŀ	1.3	1.6	1.5	1.7	3.4	1.6	9.0	1.3	1.7	2.2	2.7	0.7	*	*	1.8 8.1	8.0	1.2	5.4	1.5	1.7	1.9	1.0	*	1.4	2.0	5.6	1.1	6.9	1.6	1.7	2.2	Į.		١.	
FY2014	#	18	99	357	16	221	21	22	95	125	2,078	28	09	10	11	13	53	25	46	111	31	23	40	26	8	30	149	53	56	40	44	827	1,522	583	12,031	spital Serv	
5 FY2014	County	Perry	Robertson	Rutherford	Stewart	Sumner	Trousdale	Wayne	Williamson	Wilson	Region 5	Benton	Carroll	Chester	Crockett	Decatur	Dyer	Fayette	Gibson	Hardeman	Hardin	Haywood	Henderson	Henry	Lake	Lauderdale	Madison	McNairy	Obion	Tipton	Weakley	Region 6	Region 7 (Shelby)	N/A	ennessee 1	Data source: TDMHSAS-funded admissions to mental health services in regional mental health institutes and private psychiatric hospitals that contract with TDMHSAS: Division of Hospital Services	
Gud	Y Y					Ŋ															u	0											Regio		1	ith TDMI	
FY2016	Rate	*	1.5	2.9	2.8	3.1	1.5	*	2.7	2.4	3.1	2.9	1.6	*	3.0	1.7	2.5	3.3	2.3	2.5	1.8	2.4	2.5	2.4	3.9	2.1	3.8	2.4	1.9	2.8	1.4	1.3	2.1	1.6	*	ntract w	
FY2	*	10	56	99	117	29	56	\$	98	140	28	33	23	2	91	36	1,921	1,778	80	27	54	97	100	79	88	41	24	34	29	56	36	32	142	225	\$	s that co	
FY2015	Rate	*	1.7	2.7	3.4	3.2	*	*	3.7	2.3	4.3	4.0	1.6	*	2.9	1.4	2.9	3,3	2.6	1.7	1.5	3.1	2.2	2.2	2.5	3.7	*	2.0	2.0	3.1	1.5	2.0	5.6	1.4	*	hospital	
FYZ	#	10	29	49	140	30	18	\$	49	136	108	46	23	11	88	29	2,216	1,740	90	19	45	127	98	73	28	2	10	28	65	29	39	49	177	198	<5	/chiatric	
FY2014	Rate	*	1.7	3.0	2.5	3.3	*	*	3.3	1.8	4.1	1.7	*	*	2.2	1.0	2.6	3.2	2.2	3.1	1.5	3.1	2.2	2.2	5.9	2.1	*	2.3	2.1	4.6	6.0	1.6	2.7	1.4	*	ivate ps	= ;
FYZ	#	11	29	29	105	31	11	0	44	105	103	20	15	14	89	21	1,964	1,704	78	34	45	126	28	71	29	40	11	32	67	43	24	38	180	193	<5	es and pr	
	County	Jackson	Macon	Marion	McMinn	Meigs	Overton	Pickett	Polk	Putnam	Rhea	Sequatchie	Smith	Van Buren	Warren	White	Region 3	Region 4 (Davidson)	Bedford	Cannon	Cheatham	Coffee	Dickson	Franklin	Giles	Hickman	Houston	Humphreys	Lawrence	Lewis	Lincoln	Marshall	Maury	Montgomery	Moore	tal health institute	-
g	FFIN								ო								100	Regio								-010	'n									nal men	:
FY2016	Rate	3.4	3.0	*	1.6	2.0	3.1	3.5	5.2	3.5	3.7	1.2	3.0	2.5	1.6	2.0	1.9	1.4	2.4	1.6	2.2	3.0	3.2	1.8	1.5	*	2.2	2.1	2.2	*	1.5	1.5	2.3	3.5	3.0	s in region	
FY2	#	154	167	16	72	29	394	20	530	1,412	222	124	93	63	45	36	90	09	841	99	78	51	134	59	113	16	2,061	25	178	9	70	23	32	37	830	h service	
FY2015	Rate	2.8	2.7	*	2.8	2.4	3.1	3.2	5.1	3.4	3.6	1.7	3.9	2.5	2.1	1.4	1.9	1.4	2.4	1.3	2.3	2.8	3.5	2.3	1.5	* [2.3	1.9	2.8	*	1.2	3.2	2.3	4.3	3.6	tal healt	=
FY2	#	128	147	17	125	35	289	47	516	1,404	215	171	123	63	28	56	94	28	860	53	82	49	149	38	114	17	2,170	23	229	16	57	48	32	45	997	to men	,
FY2014	Rate	3.1	2.3	*	2.1	3.2	2.8	3.6	4.4	3.1	3:2	1.2	3.4	1.0	1.7	1.2	1.7	1.7	1.9	1.5	1.4	2.0	3.5	2.2	1.4	1.4	1.9	2.0	2.5	*	1.1	2.6	*	3.6	3,4	mission	
FY2	#	141 126 12 92 92 47 47 352 52								1,270	203	189	96	20	43	31	73	09	853	65	73	47	128	37	113	22	2,083	54	202	7	21	33	17	38	939	unded ac	
, demo	commy	Carter	Greene	Hancock	Hawkins	Johnson	Sullivan	Unicoi	Washington	Region 1	Anderson	Blount	Campbell	Claiborne	Cocke	Grainger	Hamblen	Jefferson	Knox	London	Monroe	Morgan	Roane	Scott	Sevier	Union	Kegion 2	Bledsoe	Bradley	Clay	Cumberland	DeKalb	Fentress	Grundy	Hamilton	urce: TDMHSAS-f	A Marie Control of the Control of th
aga	LIED				_	1												,													6	7				Data so	Oc. 4/14

N/A includes admissions from individuals "out of state" or where the county of residence was unknown or not collected.

Data note: <5 = number of admissions less than 5 but greater than or equal to 1; 0 events reported if applicable; *Rates not reported for admissions <20; PPR=TDMHSAS Planning and Policy Region.

2017 Behavioral Health

Page Two March 29, 2018

2. Section B, Need, Item 9. Relationship to Existing Similar Services (Psychiatric Inpatient Services-Service Specific Criteria-) Page 27

It is understood that occupancy data by age category cannot be computed utilizing the JAR; however utilization trends can be provided by age category by using patient days. Please provide this information for years 2014 to 2016, including a % change column '14-'16 and a total row for all the hospitals providing inpatient psychiatric services in the primary and secondary service areas.

Attached following this page is a new table showing the increase in psychiatric patient days at all area providers, from 2014 through 2016. The entire service area has increased 14.9% in this two-year period. The PSA, which provides 70.7% of all patient days, increased 13.1% while the SSA, composed of rural providers across West Tennessee increased 19.5%. The applicant wishes to withdraw the table of patient days sent in the first supplemental response, so that this is the one with the pertinent data you wish to see,.

3. Section B, Need, Item 12. Institution for Mental Disease Classification (Psychiatric Inpatient Services-Service Specific Criteria-) Page 29

Your response to this item is noted. Do adult chemical dependency beds count toward the IMD calculation?

Yes, they do, according to the Chief Financial Officer of Crestwyn.

4. Section B, Economic Feasibility, Item 6.C. Page 60

Your response to this item is noted. Please explain the difference between the financial statements in the supplemental response where long term debt is listed as \$15,827,658 and Net Assets as \$11,668,504 in 2017 versus the financial statement in the original application that identifies \$3,353,004,000 in long term debt and total equity of \$2,167,724,000 for 2016. The capitalization ratio should be for the entity funding the proposed project.

Crestwyn Behavioral Health is funding the project. Its CFO supplied a letter affirming that, in the original application. The original application included Crestwyn's income statement; but through an oversight Crestwyn's balance sheet was omitted.

	Percent Change 2014 to 2016	4 65+ Total		5% 31.0% 25.2%	5.1% -22.1% 4.1%	3% -26.1% -10.0%	5% 90.7% -13.4%	2% 26.1% 2.5%	%0.0 %0.0 %0.0	13.1% 6.8% 13.1%	THE PERSON NAMED IN			1% 83.3% 15.2%	8% 47.4% 3.1%	8% -11.5% -10.8%		7% -22.4% -16.8%	% 58.8% 19.5%		18.8% 14.9%	
Data)	rcent Chan	0-17 18-64		15.4% 27.5%	-100.0% 5.	0.0% -2.3%	0.0% -20.5%	-21.5% 37.2%	0.0% 0.0	4.9% 16.8%				0.0% 13.1%	0.0% 50.8%	0.0% -10.8%		0.0% 302.7%	0.0% 14.0%		4.9% 15.9%	
Psychiatric Inpatient Days2014-2016 (New Supplemental Table / Schedule H Data)	Pe	100		173	17,565	748	7,336	11,790	6,104	716		100	1,437	104	2,257	3,304	3,475	3,557	134		350	
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Se			Primary Svc Area - Shelby Co.	Lakeside Behav Hith	Memphis MH Institute	Delta MC	Methodist Univ Healthcare	Saint Francis Hosp	Crestwyn Behavioral Health	PSA Total	THE REAL PROPERTY AND ADDRESS OF THE PERSON ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON ADDRESS OF THE PERSON ADDRESS OF THE PERSON AND ADDRESS	Secondary Svc Area - Other	Baptist Mem Hosp-Huntingdon	Western MH Institute	Henry County Med Center	Pathways of TN Behav Hith Svcs	Woodridge, dba Oak Hills, BH	Behavioral HIthcare Cntr - Martin	SSA Total		Service Area Total	Sources: 2015-2015 JAR Schedule H. page 32 (25 also). 2016 JAR page 38

Page Three March 29, 2018

Our first supplemental response corrected the omission by providing the Crestwyn balance sheet, and provided what we believe to be the correct capitalization ratio calculation, based on that balance sheet.

The parent company Acadia's financial statements--with the much larger debt and equity amounts you cite--were submitted in the original application only as a matter of information.

5. Section B, Orderly Development, Item 1 (Transfer Agreements), Page 66

Your response that this information is being gathered for submittal under separate cover is noted.

The three Acadia hospitals' accreditation surveys were provided in the last supplemental information filing. With respect to their surveys, the following information is available.

- 1. Crestwyn--This is a very new, TDMHSAS-licensed hospital that opened in Spring of 2016. Management says that they have not had a facility survey from TDMHSAS. The West Tennessee office of TDMHSAS did not have a record of one in their computer system yesterday, but is expected to perform a survey early in this calendar year.
- 2. TrustPoint in Rutherford County--This is licensed by the Department of Health because it still has rehabilitation beds, although most of its capacity is psychiatric. Dr. Jeff Woods, CEO, advises that Trustpoint has not had a TDH facility-wide survey and plan of correction; his Joint Commission surveys include a physical facility survey that is deemed sufficient by the Department of Health. However, he has provided an incident survey report from 2017, and a construction site survey, attached after this page.
- 3. Delta Medical Center, like Trustpoint, is licensed by the Department of Health. Its latest survey is attached after this page.



February 6, 2018:

Mr. Jeffery Woods, Administrator Trustpoint Hospital 1009 North Thompson Ln Murfreesboro TN 37129

RE: TNP531184

Dear Mr. Woods:

The East Tennessee Regional Office of Health Care Facilities conducted a Life Safety construction visit on November 29, 2017. A desk review was conducted, based on that review; we are accepting your plan of correction and are assuming that your facility is in compliance with all regulations cited as of December 12, 2017.

If you have any questions, please contact this office at (865) 594-9396 or by facsimile at (865) 594-5739.

Sincerely,

7amra 7urberville/cw

Tamra Turberville, RN, MSN
Public Health Regional Regulatory Program Manager

TT:cw

11:59 A.M.



January 26, 2017

Mr. Jeffery Woods, Administrator Trustpoint Hospital 1009 North Thompson Ln Murfreesboro TN 37129

RE: 44-0231

Dear Mr. Woods:

The East Tennessee Regional Office conducted a complaint investigation at your facility on January 17 - 19, 2017. As a result of the investigation, no deficient practice was found.

If our office may be of assistance to you, please feel free to call (865) 594-9396.

Sincerely,

7amra 7urberville/cw

Tamra Turberville, RN, MSN
Public Health Regional Regulatory Program Manager

TT: cw

TN00038422, TN00038766, TN00038861, TN00039089, TN00040195, TN00040247

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 11:59 A.M. (X3) DATE SURVE COMPLETED COMPLETED COMPLETED STREET ADDRESS, CITY, STATE, ZIP CODE 1009 NORTH THOMPSON LANE MURFREESBORO, TN 37129 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED (X4) PROVIDER SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE COMPLETED (X4) ID PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE	CENTERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES		Supplementa	MB NO	APPROVI
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TITLE

(X8) DATE

DRINTED, 04/08/0047

PRINTED: 01/26/2017

Supplemental #2RM APPROVED

(X2) MULTIPLE CONSTRUCTION March 29, 2018 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _____ 11:59 A.M. B. WING TNP531184 01/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1009 NORTH THOMPSON LANE TRUSTPOINT HOSPITAL MURFREESBORO, TN 37129 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) H 001 1200-08-01 Initial H₀₀₁ During investigation of complaint #38422, #38766, #38861, #39089, #40195, and #40247 completed 1/17/17 to 1/19/17 no deficiencies were cited related to the complaint under Chapter 1200-08-01, Standards for Hospitals. Division of Health Care Facilities

STATE FORM

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

	OP DEFICIENCIES F CORRECTION	(XI) PROVIDENBUPPLIENGLIA IDENTIFICATION NUMBER:	(X2) MULTI	iple construction IG 02 - Building	COMPLE COMPLE	
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DELTA M	EDICAL CENTER		ı	2000 GETWALL RD MEMPHIS, TN \$8418		
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N. of Co.	Heavening on the second	<u>, </u>		Name of the Control o		
111	augost!	SUPPLIER REPRESENTATIVE'S SIGNATURE sterisk (*) degotos e deficioacy which the insti on to the parlents. (See Instructions.) Except		CEU	_2	14/

DEPARTMENT OF HEALTH AND HUMAN SERVICES . CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/24/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT C	e dercirectes correction	MEDICAID SERVICES (X3) PROVIDENSUPPLIERICLIA IDENTIFICATION RUMBER: 440159	E. WINO	TE CONSTRUCTION 0 02 - BUILDING	COMPLETE	VEY 50 1/20/13
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	Esser on observalk	ly failed to maintain night		2) The procedure for implement plan of correction for the spack! Night lights in patient rooms wi monthly with all ofter emergenc Charge Nurse may report any or order system at any time.	c delictency cited. It he chocked by lighting. Also, the diages via the work	
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PRINTED: 01/17/2013 FORMAPPROVED

H1408 1200-8-1-14 (2)(a)4, Disaster Preparedness (2) Physical Facility and Community Emergency Plans. (3) Physical Facility (Internal Situations). (4) Drills of the disaster preparedness plan shall (5) Physical Facility (Internal Situations). (6) The will be conducted at least once a year with the focus varying from ternado, bomb, flood, and flantinguake. (7) How the facility will be conducted at least once a year with the focus varying from ternado, bomb, flood, and flantinguake. (8) Physical Facility (Internal Situations). (9) How the facility will prevent the same deficiency from recurring. (10) As schedule will be created for the drills.		OF DEFIDIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIE IDENTIFICATION NUI TNIPES1108	MBER:	P. MING		COMPI	SURVEY LETED
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LABORATORY DIRECTOR'S OR PROVIDER/SUFFLIER REPRESENTATIVE'S SIGNATURE

90B021

Page Four March 29, 2018

6. Section B, Quality Measures

Your response to this item is noted; however Items (3) (d)-(e) and (3)(p) 1.-3. can be applied to the existing facility. Please provide a response to each of these items and any other items that have already been met by the existing facility.

Following are the requested responses to these items:

Please verify and acknowledge the applicant will be evaluated annually whether the proposal will provide health care that meets appropriate quality standards upon the following factors:

- (3) Quality. Whether the proposal will provide health care that meets appropriate quality standards may be evaluated upon the following factors:
- (d) Whether an existing healthcare institution applying for a CON has maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action shall be considered;

Crestwyn Behavioral Health has maintained compliance with all applicable federal and state regulation since its opening in 2015.

(e) Whether an existing health care institution applying for a CON has been decertified within the prior three years. This provision shall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility;

Crestwyn Behavioral Health has never been decertified.

(p) For Inpatient Psychiatric projects:

1. Whether the applicant has demonstrated appropriate accommodations for patients (e.g., for seclusion/restraint of patients who present management problems and children who need quiet space; proper sleeping and bathing arrangements for all patients), adequate staffing (i.e., that each unit will be staffed with at least two direct patient care staff, one of which shall be a nurse, at all times), and how the proposed staffing plan will lead to quality care of the patient population served by the project;

Page Five March 29, 2018

Crestwyn meets or exceeds all State licensure standards and national accreditation standards for these aspects of its patient care. Patients with aggression issues are segregated in the adult wings from those who are not. Crestwyn does not yet accept children younger than 10 years of age, and then only rarely at the request of Youth Villages and with physician approval. But any young patient needing quiet is afforded that appropriately. Each patient bedroom has its own full bath and has a bed for each occupant. Crestwyn has submitted its staffing information in the application and first supplemental response; each unit is staffed with at least two direct patient care staff (including a nurse) at all times, and one-to-one staffing is maintained for any patient at risk for harming himself or herself or others.

2. Whether the applicant has documented its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring systems; and

The response below pertains to Crestwyn Behavioral Health, but it also reflects the standard QAPI system in place at all three Acadai hospitals in Tennessee:

Quality Assurance and Performance Improvement (QAPI) is an essential and required component of the services rendered at Crestwyn Behavioral Health. QAPI is the combination of two aspects: Quality Assurance and Performance Improvement. Quality assurance is a "process of meeting quality standards and assuring that care reaches an acceptable level." Performance Improvement is "a pro-active and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent problems."

When combined, QAPI proactively examines policies and procedures to ensure systematic compliance, quality care, and patient safety.

To ensure this occurs, monthly Performance Improvement ("PI") Meetings are scheduled with the CEO, CFO, Risk Manager, Director of Clinical Services, Chief Nursing Officer, Infection Control Nurse/Nurse Educator, Director of Intake, Director of Utilization Review, Director of Human Resources, Director of Plant Operations, Patient Advocate,

Page Six March 29, 2018

Pharmacist, and Director of Outpatient Services. During the meeting they review aggregation and analysis of data from the prior month, set goals and plans for improvement, and review previous goals and achievements. A copy of the outline of such a meeting is attached following this page.

Items that are included in the monthly meetings include:

- Utilization Reports (Patient days, AMA, readmission rates, etc.)
- Intake Report (Door-to-floor times and EMTALA Compliance)
- Human Resources Report (Turnover rate, Terminations, New Hires, Employee Performance Evaluations, etc.)
- Environmental Rounds (Physical safety of the building and compliance with environment of care policies).
- Risk Management (Incident reporting analysis, Seclusion and Restraint Trends)
- Facility Safety Committee Meeting (Monthly Meeting that focuses on improvement of safety of patient and employees).
- Discharge Calls (Follow-up to address questions and concerns from patients in hopes of decreasing readmission rates).
- Patient Concerns and Grievances (Analysis of the types of concerns, resolution of concerns and trends).
- Pharmacy report and recommended areas of improvement.

Crestwyn Behavioral Health strives to provide exceptional care. When incidents or grievances occur, staff communicates the information to the appropriate care team members to ensure that the incident or concern is promptly and effectively addressed and resolved. Addressing, investigating and resolving incidents and concerns is a continuous process.

Information from QAPI meetings is presented to the Medical Executive Committee (MEC) meeting that is held every other month. The Medical Director and the medical staff (physicians and psychiatrists) attend to provide insight to the rest of the clinical care teams on any areas of concern. Ideas to improve the clinical and medical care are discussed and plans are adopted. Monitoring of progress in execution of these plans is reported to QAPI and from there to the Medical Executive Committee to ensure appropriate and thorough oversight.

Crestwyn Behavioral Health Performance Improvement Committee Meeting Date

	Members Present	Members Absent	Guest
CEO			
CFO			
Risk Manager/PI			
Director of Human Resources			
Director of Plant Operations			
Chief Nursing Officer			
Director of UR			
Director of Clinical Services			
Director of HIM			
Director of Intake			
Director of Outpatient			
Patient Advocate			
Pharmacist in Charge			
Director of Business Development			
Infection Control Nurse			
Patient Advocate			

Responsible Party	京 は 信 の 一 二 まかな			leme 1 29, A.M.	2(ta 01:	l #2 8
Recommended Actions	THE RESERVE THE PARTY OF THE PA						
Discussion							
Agenda	Order	Approval of Minutes	Old Business	New Business	Intake Report	Utilization Review	HBIPS Reports
	Call to Order	Approv	ï	II.	ΞĮ.	IV.	ν.

HR Dashboard	EOC Safety Rounds	Nursing	Infection Control	Acadia Scorecard	Seclusions and	Restraints	Incidents	Patient Satisfaction	Survey	XIV. Patient Safety	Committee Meeting	CMS Survey POC	XVI. Concerns and	Grievances	XVII. Discharge Calls	Town Hall Meetings	VIV A 1:
VI.	VIII.	VIII.	IX.	Χ.	XI.		XII.	XIII.		XIV.		XV.	XVI.		XVII.	XVIII.	VIV

Supplemental #2 March 29, 2018 11:59 A.M. Page Seven March 29, 2018

3. Whether an applicant that owns or administers other psychiatric facilities has provided information on satisfactory surveys and quality improvement programs at those facilities.

The applicant has submitted its accreditation surveys from all three Acadia hospitals operating in Tennessee. In this response, the applicant has attached additional information regarding facility-wide surveys and quality improvement processes. Please see the responses above.

7. Proof of Publication

It appears that only copies of the proof of publication were provided. Please submit a copy of the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit which is supplied by the newspaper as proof of the publication of the letter of intent.

Attached at the end of this letter are a copy of the newspaper's affidavit of publication, and the public notice photocopy that was appended to the affidavit. Please accept these in lieu of new originals, which can not be obtained by your deadline for submitting this response.

Thank you, Mark, for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please email or telephone me so that we can respond in time to be deemed complete.

Respectfully,

In Stilelloom

John Wellborn Consultant

The Commercial Appeal Affidavit of Publication

STATE OF TENNESSEE COUNTY OF SHELBY

Personally appeared before me, Glenn W. Edwards, a Notary Public, Helen Curl, of MEMPHIS PUBLISHING COMPANY, a corporation, publishers of The Commercial Appeal, morning and Sunday paper, published in Memphis, Tennessee, who makes oath in due form of law, that she is Legal Clerk of the said Memphis Publishing Company, and that the accompanying and hereto attached advertisement was published in the following editions of The Commercial Appeal, to-wit:

March 10, 2018

Subscribed and sworn to before me this 12th day of March, 2018.

My commission expires January 20, 2020

@10. 38016

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\$19.95 \$18.99 \$34.99

\$15,95 6.95 • Doors. fun than a bunny. 6 yell/white females 3 males, parents on site AKC reg. 5&W, dewclaws removed. (901)826-4265

Legal Notices

Legal Horices NOTIFICATION OF INTENT

TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq. and the Rules of the Health Services and Development Agency, that Crestwyn and the nurse of the result describes and menaged by Crestwyn Behavloral Health (a behavloral health hospital), owned and menaged by Crestwyn Health Group, LLC (a limited liability company), intends to file an application for a

add fourteen (14) licensed beds to its facility at 9485 Crestwyn Hills Cove. Memphis, Certificate of Need to TN 38125, at a capital cost estimated at \$100,000.

The facility is licensed for 68 Mental Health Hospital bads by the Department of The tacking is licensed for but mental Health Hospital dees by the Department of Mental Health and Substance Abuse Services. These conest of 33 adult psychiatric beds, 16 child/adolescent psychiatric beds, and 17 adult dual diagnosis/substance.

This project proposes to increase total licensed beds to 80 beds. The edult units will be increased to 36 beds (increase of 3). The child/adolescent units will be increased to 36 beds (increase of 18). The dual diagnosis/substance abuse beds increased to 32 beds (increase of 18). The dual diagnosis/substance abuse beds will be reduced from 17 beds to 12 beds (decrease of 5). All bed increases will be in existing semi-private aize patient rooms that are currently used as single rooms. The project requires no construction. The project does not contain major medical equipment or initiate or discontinue any health service.

The anticipated date of filing the application is on or before March 15, 2018. The contact person for the project is John Wellborn, who may be reached at Development. Support Group, 4219 Hillsboro Fload, Suite 210. Nashville, TN 37215. (615) 665-2022. Upon written requiset by interested parties, a local Fact-Finding public healing that he confluence. Written requisets for healing should be confluenced. Written requisets for healing should be confluenced. shall be conducted. Written requests for hearing should be sent to the following

Health Services and Development Agency

Tennessee Health Services and Development Agency

Andrew Jackson Building, 9th Floor

500 Deaderlok Street

Nashville, TN 37243

Pursuant to TCA Sec. 88-11-1807(c)(1): (A) any health care institution wishing to Pursuant to TCA Sec. 88-11-1607(c)(1): (A) any health care institution wishing to oppose a Certificate of Need application must file a written objection with the Health Services and Development Agency no later than filesn (15) days before the regularly acheduled Health Services and Development Agency meeting at which the application is originally scheduled, and (b) any other person wishing to oppose the application must file written objection with the Health Services and Development. Agency at or prior to the consideration of the application he the Agency. Agency at or prior to the consideration of the application by the Agency.



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larch, 2018

AFFIDAVIT

STATE OF TENNESSEE
COUNTY OF DAVIDSON

NAME OF FACILITY: CRESTWYN BEHAVIORAC HEACTH

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the and subscribed before me, a Notary Public, this the switness my hand at office in the County of Davidson, State of Tennessee.

NOTARY PUBLIC

My commission expires

HF-0043

Revised 7/02

STATE OF TENNESSEE NOTARY PUBLIC TO THE PUBL